

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last James Vernon Abbott		2a. DATE OF DEATH Month Day Year January 6, 1969		2b. HOUR A.M. or P.M. 9:05 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 27, 1896	6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel County, Md.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) EXECUTIVE	12b. KIND OF BUSINESS OR INDUSTRY INS	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. CITY OR TOWN Pasadena	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 302 Christy Road	
14. FATHER'S NAME First Middle Last CHARLES BARNES ABBOTT	15. MOTHER'S MAIDEN NAME First Middle Last CARRIE RUSSELL	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a. or unknown) (If yes give war or dates of service) YES WWI		
16b. SOCIAL SECURITY NO.		17. INFORMANT Address MRS EARL B WALKER #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD - Cardiomegaly</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cor - pulmonale</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia: Severe pulm. Emphysema</u> years				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. OF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Summer, 1968</u> to <u>present</u> , 19 <u>69</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>1-5</u> 19 <u>69</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, <u>(I)</u> <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.				
22b. SIGNATURE <u>Peter F. Verkouw</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 1-6-1969
22d. PHYSICIAN'S NAME (Type) Peter F. Verkouw, M. D.		22e. ADDRESS 1407 Forest Drive, Annapolis, Maryland		
23a. BURIAL, CREMATION, REMOVED (Specify) BURIAL	23b. DATE JAN 9 1969	23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF Cem.	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD		25a. REC'D BY REGISTRAR JAN 9 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1. The Department of the Interior has been advised that the Bureau of Reclamation is planning to construct a dam on the Colorado River at the mouth of the Grand Canyon. This project is being financed by the Federal Government and the State of Arizona. The dam is expected to be completed by 1955. It will have a height of 217 feet and will generate 1,300 megawatts of electricity. The project is being opposed by the National Park Service and the National Audubon Society. They claim that the dam will destroy the natural beauty of the Grand Canyon and will harm the wildlife. The Department of the Interior is currently reviewing the project and will make a decision by the end of the year.

2. The Department of the Interior has also been advised that the Bureau of Reclamation is planning to construct a dam on the Colorado River at the mouth of the Grand Canyon. This project is being financed by the Federal Government and the State of Arizona. The dam is expected to be completed by 1955. It will have a height of 217 feet and will generate 1,300 megawatts of electricity. The project is being opposed by the National Park Service and the National Audubon Society. They claim that the dam will destroy the natural beauty of the Grand Canyon and will harm the wildlife. The Department of the Interior is currently reviewing the project and will make a decision by the end of the year.

3. The Department of the Interior has also been advised that the Bureau of Reclamation is planning to construct a dam on the Colorado River at the mouth of the Grand Canyon. This project is being financed by the Federal Government and the State of Arizona. The dam is expected to be completed by 1955. It will have a height of 217 feet and will generate 1,300 megawatts of electricity. The project is being opposed by the National Park Service and the National Audubon Society. They claim that the dam will destroy the natural beauty of the Grand Canyon and will harm the wildlife. The Department of the Interior is currently reviewing the project and will make a decision by the end of the year.

Very truly yours,  
John Edgar Hoover, Director

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00106											
Item#5Film#G408 11/22/69 vmp											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Ionia D. Allen</b>						2a. DATE OF DEATH <b>1 Month 15 Day 69 Year</b>			2b. HOUR <b>2:55A M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6-3-83 82</b>			6. AGE (In years last birthday) <b>86 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>A.A.Co.</b>					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>A.A.Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>114 5th. Ave. S.E.</b>		
14. FATHER'S NAME First Middle Last <b>Robert W. Griffith</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary E. Donaldson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> NO			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Elva Bailey, 108 5th Ave. S. E.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive Bronchopneumonia</b> <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Generalized arteriosclerosis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> , 19 <b>69</b> , to <b>1/15</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Hilary T. O'Herlihy M.D.</b>						DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/15/69</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>18 Jan. 69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Friendship Airport AA, Md.</b>			
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>						25a. REC'D BY REGISTRAR <b>JAN 17 1969</b>					

00108



*Antennae Brachymeria*

*Spunthia antennalis*

1/12/64

*Antennae Brachymeria*

8

*Antennae Brachymeria*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First MATTHEW		Middle THOMAS ALVIN		Last ANDERSON		2a. DATE OF DEATH Month Day Year January 29 1969		2b. HOUR 1451 M	
3. SEX Male		4. RACE Negroid		5. DATE OF BIRTH January 25, 1888			6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.						
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Navy			12b. KIND OF BUSINESS OR INDUSTRY Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt. 5, Box 1			
14. FATHER'S NAME First Middle Last Matthew NMN Anderson			15. MOTHER'S MAIDEN NAME First Middle Last Katie NMN Stansbury									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give war or dates of service) 1920-1947		16b. SOCIAL SECURITY NO. 230-22-3560		17. INFORMANT Annapolis, Md. Address Clara Margaree Anderson -Rt. 5-Box 40						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONITIS AND MULTIPLE LUNG ABSCESSSES</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> , 19 <u>69</u> , to <u>1-29</u> , 19 <u>69</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>1-29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.												
22b. SIGNATURE <u>A.C.J. Brickel</u>				DEGREE LT MCUSNR		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED January 30, 1969				
22d. PHYSICIAN'S NAME (Type) A.C.J. BRICKEL				22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE FEBRUARY 3-69		23c. NAME OF CEMETERY OR CREMATORY PINE LAWN		23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland						
24. FUNERAL DIRECTOR C.E. HICKS 111				Annapolis, Md.		25a. RECEIVED BY REGISTRAR FEB 5 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

THE UNITED STATES OF AMERICA

IN SENATE

January 10, 1910

REPORT

OF THE

COMMISSIONERS OF THE GENERAL LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ON MAY 1, 1899

AND A RESOLUTION PASSED BY THE HOUSE OF REPRESENTATIVES

ON MAY 1, 1899

AND A RESOLUTION PASSED BY THE HOUSE OF REPRESENTATIVES

ON MAY 1, 1899

AND A RESOLUTION PASSED BY THE HOUSE OF REPRESENTATIVES

ON MAY 1, 1899

AND A RESOLUTION PASSED BY THE HOUSE OF REPRESENTATIVES

ON MAY 1, 1899

AND A RESOLUTION PASSED BY THE HOUSE OF REPRESENTATIVES

ON MAY 1, 1899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last Ida Belle Archer			2a. DATE OF DEATH Month Day Year 1 28 69		2b. HOUR P 4:10M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 11 21 1872		6. AGE (In years last birthday) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Vermont		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Knollwood Manor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY xx			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Queen Annes		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 19 Bay Side Drive	
14. FATHER'S NAME First Middle Last Frank Vassar			15. MOTHER'S MAIDEN NAME First Middle Last Louise Farland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 018079578-D		17. INFORMANT Address L. Blandford, 19 Bay Side Dr. Stevensville					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (the hospital) attended the deceased from April 17, 1968, to Jan 25, 1969, that (I) (we) saw the deceased alive on Jan 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ray M. Smith, M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 26, 1969		
22d. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.					22e. ADDRESS Severna Park, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APRIL 69		23c. NAME OF CEMETERY OR CREMATORY UNION		23d. LOCATION (City or Town) MOOSUP		(County) (State) CONN.	
24. FUNERAL DIRECTOR Edgar L. Lane - CHURCH HILL MD					25a. REC'D BY REGISTRAR DATE 28 1969		25b. REGISTRAR'S SIGNATURE		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00109

00109

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <b>HEINZ GUNTHER BALTRUSCH</b>			2a. DATE KNOWN OF DEATH Month <b>JAN</b> Day <b>18</b> Year <b>1969</b>			2b. HOUR <b>A</b> M.			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>APRIL 9, 1935</b>	6. AGE (In years last birthday) <b>33</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>JAN</b> Day <b>18</b> Year <b>1969</b>			
7a. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Alien Citizen</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>AACo</b>			
10. CITY OR TOWN OF DEATH <b>Deale, Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>BRICKLAYER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Deale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Box 46 Mason Beach</b>	
14. FATHER'S NAME First <b>WILHELM</b> Middle <b>BALTRUSCH</b> Last <b>BALTRUSCH</b>			15. MOTHER'S MAIDEN NAME First <b>LUCY</b> Middle <b>MARIA</b> Last <b>POHL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577 66 9047</b>		17. INFORMANT <b>SANDRA BALTRUSCH</b>		ADDRESS <b>Box 46 Deale, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide</b> <b>9521</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>E. Linhardt</b>		EXAMINER'S NAME (Type) <b>E. Linhardt</b>		M.D.		22b. DATE SIGNED <b>1-18-69</b>		ADDRESS (Street, city, town, or county) <b>Deale</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/22/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>SCITLAND PG MD</b>			
24. FUNERAL DIRECTOR <b>Hardesty Funeral Home, Gaberville MD</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 28 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

2010

2010-2011

2010

2010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Charles			EDWARD BARTLETT			January 8, 1969		6:15 M		
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		March 8, 1893		75 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Massachusetts		U.S.A				Anne Arundel County		INSURANCE		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel General Hospital			LIFE INS		INSURANCE		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, IN TSP		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1810 Bay Ridge Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
EDWARD			Barthett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No			065 09 1675		JOAN H. BARTLETT		# 13			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2-3 days</u> <u>Unknown</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/27, 1967</u> to <u>1/8, 1969</u> , that (I) (we) lost saw the deceased alive on <u>1/8, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>R. I. Hochman, MD</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/9/69</u>			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Richard I. Hochman, M. D.					16 Murray Avenue, Annapolis, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
CREMATION		1-11-69		Ft. Lincoln		BLADESBURG P.G. MD.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
John M. Lybrook Annapolis Md.		DATE		JAN 14 1969		Charles Judge				

Agitation

100

100

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <b>CURLEY</b>						2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> <b>1-1</b> 19 <b>69</b>		2b HOUR <b>M</b>		3 SEX <b>Male</b>	
4 RACE <b>American Indian</b>		5 DATE OF BIRTH <b>10-26-1941</b>		6 AGE (in years just birthday) <b>27</b> YRS		7 IF UNDER YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month <b>January</b> Day <b>1</b> Year <b>19 69</b>	
7a BIRTHPLACE (State or foreign country) <b>TENN</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>ANNE ARUNDEL</b>		
10 CITY OR TOWN OF DEATH <b>Jessup P.</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Simms Lane</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>				13b COUNTY <b>Anne Arundel</b>		13c CITY OR TOWN <b>Jessup</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Route 175</b>	
14 FATHER'S NAME First <b>CURT</b> Middle <b>Bell</b> Last <b>Benton</b>				15. MOTHER'S MAIDEN NAME First <b>Benton</b> Middle <b>Dehnum</b> Last <b>Dehnum</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16b SOCIAL SECURITY NO. <b>408-64-8814</b>		17. INFORMANT <b>Arch Bell</b>		ADDRESS <b>SHREVEVILLE RT 4 TENN</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b> <b>170X</b> DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <b>7:00 P.M. 1-1 19 69</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 18b) <b>Shot in gun battle after shooting his wife and two police officers</b>					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Simms Lane</b>		21f. LOCATION Street or R.F.D. No <b>Anne Arundel</b>		City or Town <b>Md.</b>		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Charles S. Springate</b>				M.D. <b>Charles S. Springate, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <b>January 2, 1969</b>	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>1-5-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEM.</b>		23d LOCATION (City or Town) (County) (State) <b>SHREVEVILLE, MONROE, TENN</b>					
24 FUNERAL DIRECTOR <b>Higinbotham Slack</b>				ADDRESS <b>ELICOTT CITY, MD.</b>		25a REC'D BY REGISTRAR <b>DAIAN 7</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>JOHN</b> First Middle Last <b>BEREZNE</b>						2a. DATE OF DEATH <b>JANUARY</b> Month Day <b>30</b> Year <b>1969</b>			2b. HOUR <b>6:30 P M</b>			
3 SEX <b>male</b>		4 RACE <b>Cau.</b>		5 DATE OF BIRTH <b>JANUARY 19-1898</b>			6 AGE (In years last birthday) <b>71</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b>			12b. KIND OF BUSINESS OR INDUSTRY			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Conv. Ctr.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Labor-Retired Armco Steel Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. before admission) STATE <b>MD.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Edgemere</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2911 Ritchie Ave. Baltimore 21219</b>				
14 FATHER'S NAME First Middle Last <b>Michael Berezne</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Glinski</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes (Not During War Time)</b>				16b. SOCIAL SECURITY NO <b>216-03-0904</b>		17 INFORMANT (Wife) <b>Mrs. Suzanna Berezne, 2911 Ritchie Ave.</b>						
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple CVA's</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD &amp; Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Jack I. Stern, MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>1/30/69</b>				
22a. PHYSICIAN'S NAME (Type) <b>JACK I. STERN, MD</b>				22e. ADDRESS <b>425 S.E. Ritchie Hwy Glen Burnie, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/3/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				ADDRESS		25a. RECEIVED BY REGISTRAR <b>FEB 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

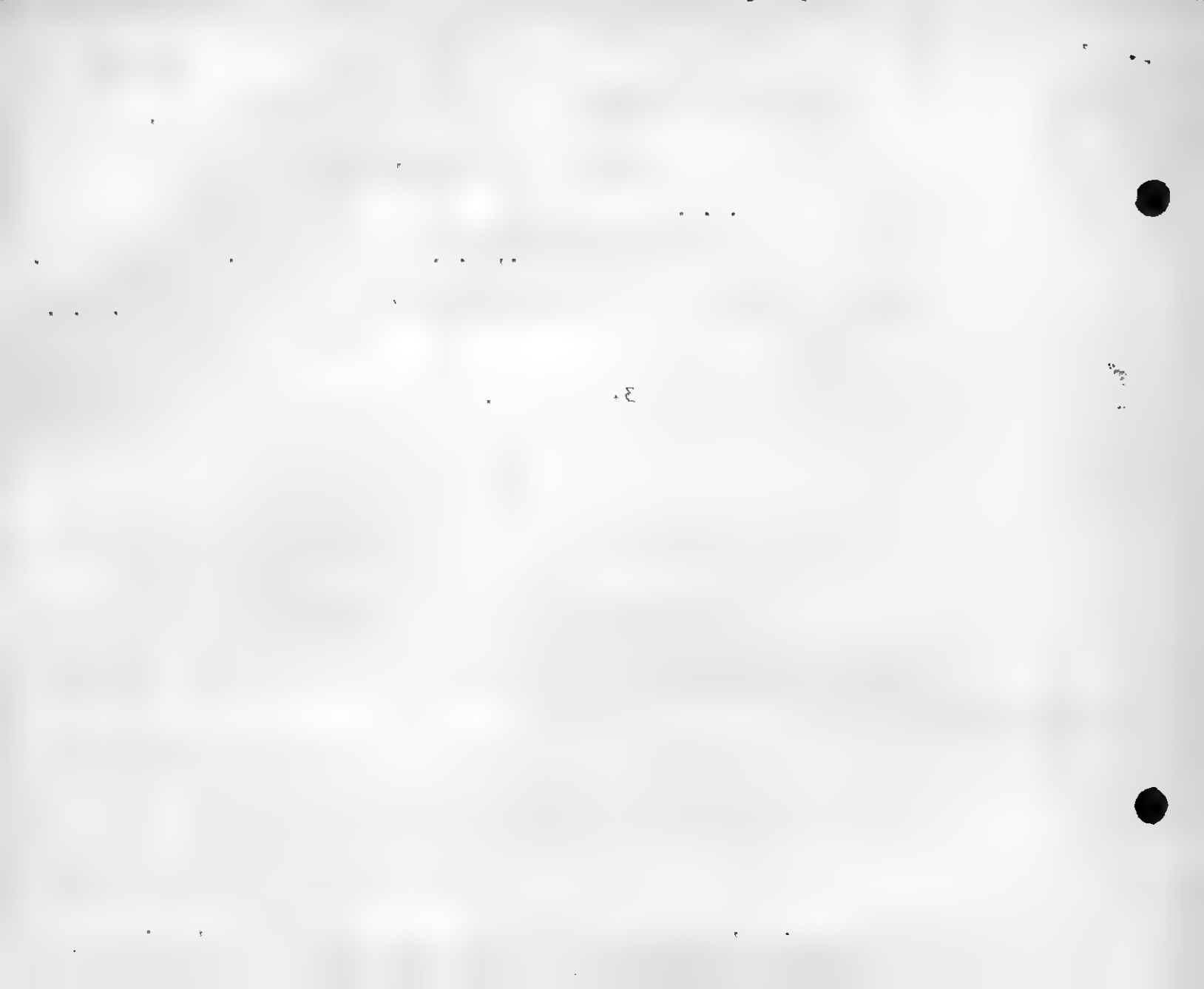


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
MICHAEL			BENEDICT		BLUM		JANUARY 17, 1969		2b. HOUR		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
MALE			WHITE			MARCH 21, 1881			87 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			U.S.A.						ANNE ARUNDEL		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE			304 CENTRAL AVE., N.W.			BARBER (ret.)			SELF EMP.		
13a. US. AL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY (L.M. 157) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND			ANNE ARUNDEL			GLEN BURNIE			304 CENTRAL AVE., N.W.		
14. FATHER'S NAME			First			Middle			Last		
HENRY			BLUM			ALICE			MARINER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address		
NO			212 34 8986			MRS. BARBARA BLUM (wife)			SAME AS # 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer Bladder</u>										Unknown	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Dec 10, 1950, to Jan 17, 1969, that (I) (we) saw the deceased alive on Jan 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death											
22b. SIGNATURE <u>C J Mendelis M.D.</u>						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1-18-69	
22d. PHYSICIAN'S NAME (Type) <u>C J Mendelis</u>						22e. ADDRESS <u>2308 Edmondson Ave Balto Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			JAN. 21, 1969			NEW CATHEDRAL			GLEN BURNIE, MD.		
24. FUNERAL DIRECTOR <u>R V Singleton</u>			SINGLETON FUNERAL HOME			25a. DECEASED BY REGISTRAR <u>JAN 22 1969</u>			25b. SIGNATURE <u>[Signature]</u>		
			GLEN BURNIE, MARYLAND			DATE					



**HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Beulah			C. Bowser			Month Day Year Jan. 18 1969			8:40 A.M.
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS.
F	W		November 28, 1886			82 YRS	MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Anne Arundel Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Annapolis			Bay Manor			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Glen Burnie			219 Poplar Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Seth Brooks			Amanda Redding						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
					Mr. George Bowser, 4012 Raleigh Road 21208				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular disease</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>and</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic emphysema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 26, 1968</u> , to <u>Jan 18, 1969</u> , that (I) (we) lost saw the deceased alive on <u>Jan 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ray M. Smith</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>Jan 18, 1969</u>		
22d. PHYSICIAN'S NAME (Type) <u>Ray M. Smith M. D.</u>					22e. ADDRESS <u>Hahn Professional Bldg., Severna Park, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Md.			
BURIAL		1-21-1969		Glen Haven Cemetery		Glen Burnie, Anne Arundel Co.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Howard H. Hubbard, 4107 Wilkens Ave 21229					JAN 21 1969		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

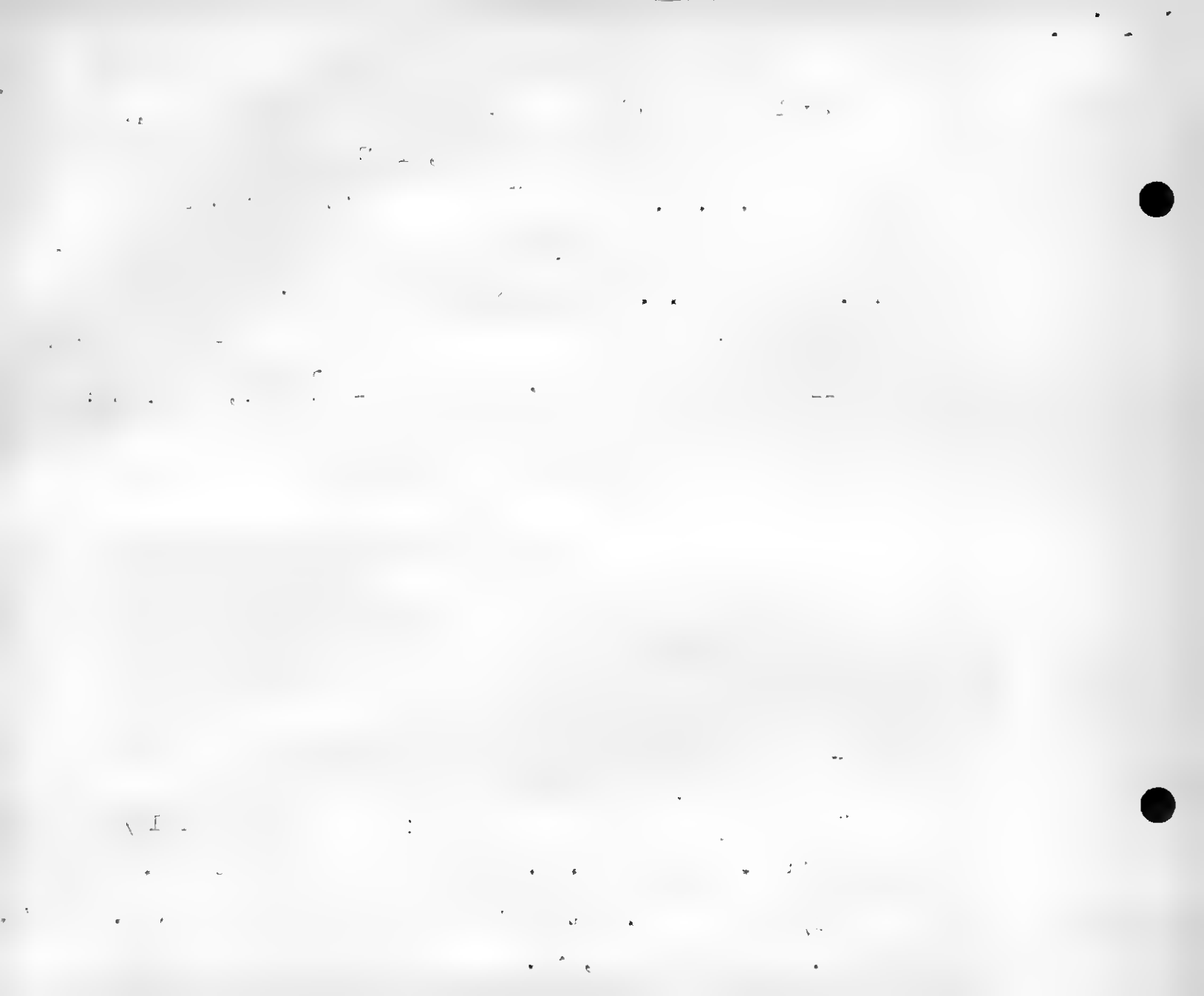
00115

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00115

1. DECEASED NAME (Type or print) <b>Hazel Louise Brady</b>			2a. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>1969</b>			2b. HOUR P. <b>1:45 M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 1, 1921</b>		6. AGE (In years last birthday) <b>47</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>18</b> HOURS <b>1</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.				
10. CITY OR TOWN OF DEATH <b>Harwood</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Box 43</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Harwood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Box 43</b>		
14. FATHER'S NAME First <b>Thomas</b> Middle <b>Edgar</b> Last <b>Hagan</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>--</b> Last <b>Higgs</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Box 43, Archie Brady - Harwood, Maryland:</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolus</b> 51771 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Ch. Pancreatitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 6 yrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1950</b> to <b>18 Jan 1969</b> , that (I) (we) last saw the deceased alive on <b>16 Jan 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robert B. Sasscer</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>1/18/69</b>						
22d. PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M. D.</b>				22e. ADDRESS <b>Upper Marlboro, Md. 20870</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/21/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthew's Cem:</b>		23d. LOCATION (City or Town) (County) (State) <b>Seat Pleasant (Pr. Geo), Md.</b>				
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 29 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



## CERTIFICATE OF DEATH

00116

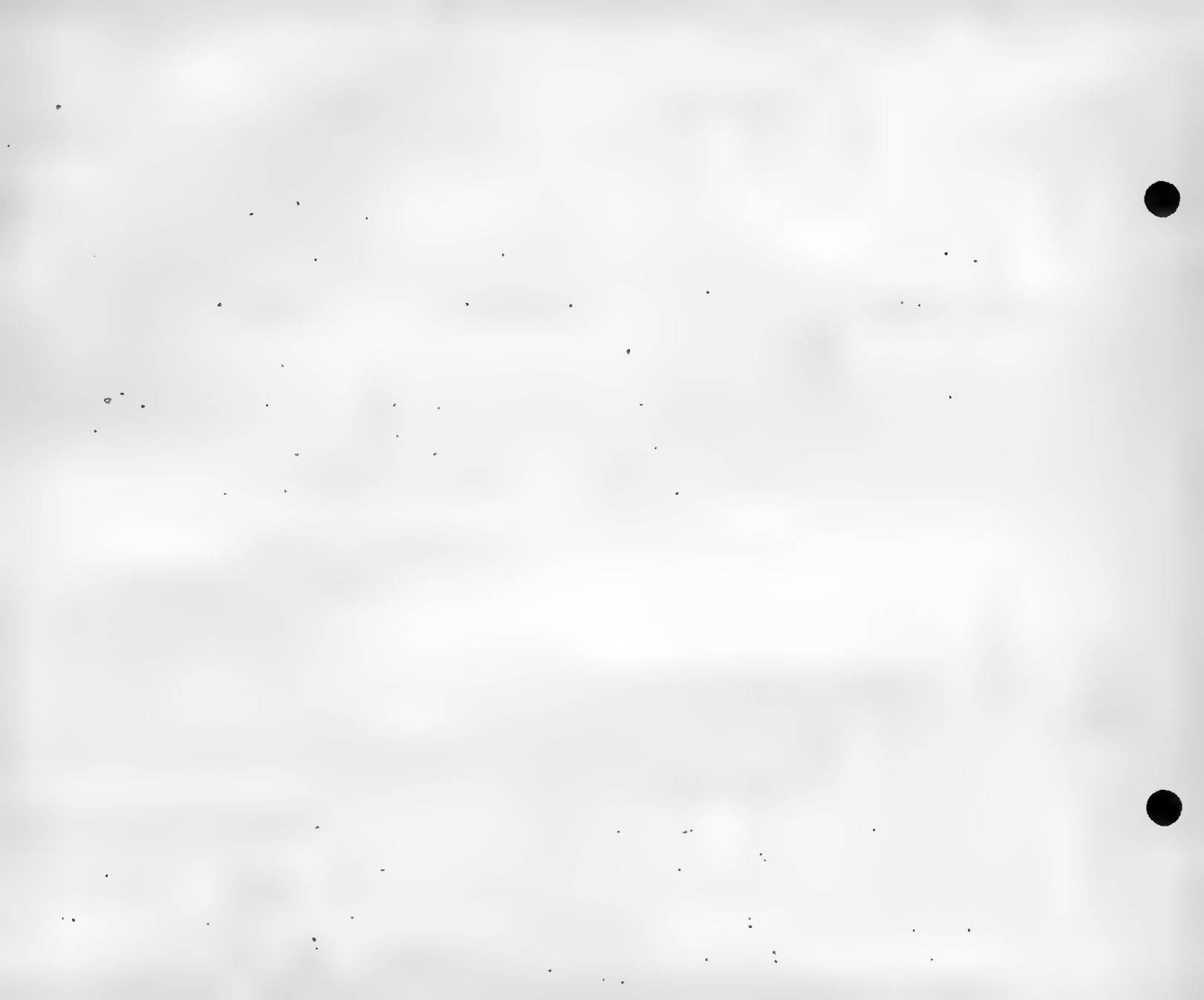
00116

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Jennie				Brice	Month	Day	Year	5:15p M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	Negro		10/26/73		95 YRS.		MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CIT. ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
unknown	USA				Anne Arundel Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville		Crownsville State Hospital			Housewife		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		BALTO		White Marsh			unknown		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
				unknown					unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no		unknown		Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>									
4124 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Dehydration, Uremia, Senile Brain disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>64</u> , to <u>1/2</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/2</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
<i>Alberto Gonzalez</i>						1/3/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Alberto Gonzalez		Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		1/7/69		Mt. Zion		Longview, Md.		Balt. Co.	
24. FUNERAL DIRECTOR		ADDRESS		25a. DIED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John L. Chaturan Jr. - 1701 M. & Cullah St		Baltimore, Md.		JAN 6 1969		<i>John L. Chaturan Jr.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

300 REV. 1/68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Charles Frederick BRIGGS						January 30 1969			3:30 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		Dec. 17, 1916		32 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
California		U.S.				Anne Arundel		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Annapolis			Anne Arundel Gen. Hospital			Engineer			Electronic
13a. U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1505 Circle Drive
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
GEORGE HENRY Briggs			MIRIAM BUSCH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
Yes, no, or unknown					JANE B. BRIGGS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____									3 days
DUE TO, OR AS A CONSEQUENCE OF (b) _____									3 days
DUE TO, OR AS A CONSEQUENCE OF (c) _____									6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1/27, 1969, to 1/30, 1969, that (I) (we) last saw the deceased alive on 1/30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE General Blumel					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/29/69		
22d. PHYSICIAN'S NAME (Type) GERALD A. CHURCH					22e. ADDRESS 121 Cathedral St., Annapolis, Md.				
23a. BURIAL, CREMATION REMOVAL (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2-1-69		Ft. Lincoln		PHADENSBURG P.G. M.D.			
24. FUNERAL DIRECTOR John M. Lutz & Sons Annapolis, Md.					25a. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00118

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00118

1 DECEASED NAME (Type or Print) <i>William</i> <i>Briscoe</i>			2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 1-5 1949			2b HOUR M		
3 SEX <i>Male</i>			4 RACE <i>Col.</i>			5 DATE OF BIRTH <i>4-2-1915</i>		
6 AGE (In years last birthday) <i>53</i> YRS			7 IF UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>5</i>			8 IF UNDER 24 HRS HOURS <i>1</i> MIN <i>5</i>		
7a BIRTHPLACE (State or foreign country) <i>MD</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 CITY OR TOWN OF DEATH <i>West River</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tal give street address) <i>Box 33</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>MD</i>			13b COUNTY <i>Chesapeake</i>			13c CITY OR TOWN <i>West River</i>		
14 FATHER'S NAME <i>George Briscoe</i>			15 MOTHER'S MAIDEN NAME <i>Unknown</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>		
16b SOCIAL SECURITY NO. <i>21456-0116</i>			17 INFORMANT <i>Rev. Owens</i>			18 ADDRESS <i>West River MD</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))								
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> <i>4124</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Stroke</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stroke</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No <i>1</i> City or Town <i>West River</i> County <i>Chesapeake</i> State <i>MD</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>E. Linhardt</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>1-5-49</i>		
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE <i>1-7-1969</i>			23c NAME OF CEMETERY OR CREMATORY <i>House of Prayer</i>		
23d LOCATION (City or Town) <i>West River</i>			23e LOCATION (County) <i>MD</i>			23f LOCATION (State) <i>MD</i>		
24 FUNERAL DIRECTOR <i>William Beese</i>			ADDRESS <i>Chesapeake</i>			25a JAN 15 1969		
25b REGISTRAR'S SIGNATURE <i>William Beese</i>			DATE <i>1-15-69</i>			25c REGISTRAR'S SIGNATURE <i>William Beese</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

00119

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00119

1. DECEASED-NAME (Type or print) First Middle Last <b>JOHN FALES BROOKS SR.</b>			2a. DATE OF DEATH Month Day Year <b>JAN 6 1969</b>			2b. HOUR <b>11 AM</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>MAR 2 1899</b>		6 AGE (In years lost to day) <b>69 YRS</b>	
7a. BIRTHPLACE (State or foreign country) <b>ANNAPOLIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ANNE ARUNDEL</b> Md	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>A.A. GEN HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CHEMIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>EPPING FOREST</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>JOHN GEORGE BROOKS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY NADIN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>4100</b>		17. INFORMANT <b>MRS NAOMI E. BROOKS</b>		Address <b>#13</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 YEARS</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-1-68</b> to <b>1-6-69</b> , that (I) (we) last saw the deceased alive on <b>12-17-68</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Edward S. Beck</b>				22c. DATE SIGNED <b>1-6-69</b>		22d. PHYSICIAN'S NAME (Type) <b>EDWARD S. BECK MD</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JAN 9, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS MD</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS</b>				25a. REC'D BY REGISTRAR <b>ANIAN 9</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

15 JAN 1969



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3, to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Items 7 & 13 Filed 1-10-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00120

1 DECEASED-NAME (Type or Print) <i>John</i> First Middle Last <i>Brown</i>			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>1</i> Day <i>11</i> Year <i>1969</i>			2b HOUR <i>11</i> AM							
3 SEX <i>M</i>		4 RACE <i>N</i>		5 DATE OF BIRTH <i>3-4-17</i>		6 AGE (in years last birthday) <i>51</i> YRS		7c DATE PRONOUNCED DEAD Month <i>1</i> Day <i>11</i> Year <i>1969</i>		2d HOUR <i>11</i> AM			
7a BIRTHPLACE (State or foreign country) <i>N. Carolina</i>			7b CIT ZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>ANNE ARUNDEL CO.</i>				
10 CITY OR TOWN OF DEATH <i>glen Burnie</i>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>DOA-NORTH. ARUNDEL.</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
13a US. AL. RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE <i>Maryland</i>				13b COUNTY <i>Anne Arundel</i>				13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>301 Bolivar St.</i>	
14 FATHER'S NAME First Middle Last <i>William Morehead</i>						15 MOTHER'S M maiden name First Middle Last <i>Roxie</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO <i>216-01-8570</i>				17 INFORMANT <i>Doobly Brown</i>				ADDRESS <i>301 Bolivar St</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Toxic Liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Toxic Liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Short</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>E. Linhardt</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <i>1-11-69</i>					
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county) <i>APCO</i>									
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE <i>1/14/69</i>				23c NAME OF CEMETERY OR CREMATORY <i>Baltimore Natl. Baltimore Md</i>					
24 FUNERAL DIRECTOR <i>Charles A. Rice</i>				ADDRESS <i>66 W. Barre St</i>				25a REC'D BY REGISTRAR <i>JAN 13 1969</i>					
								25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

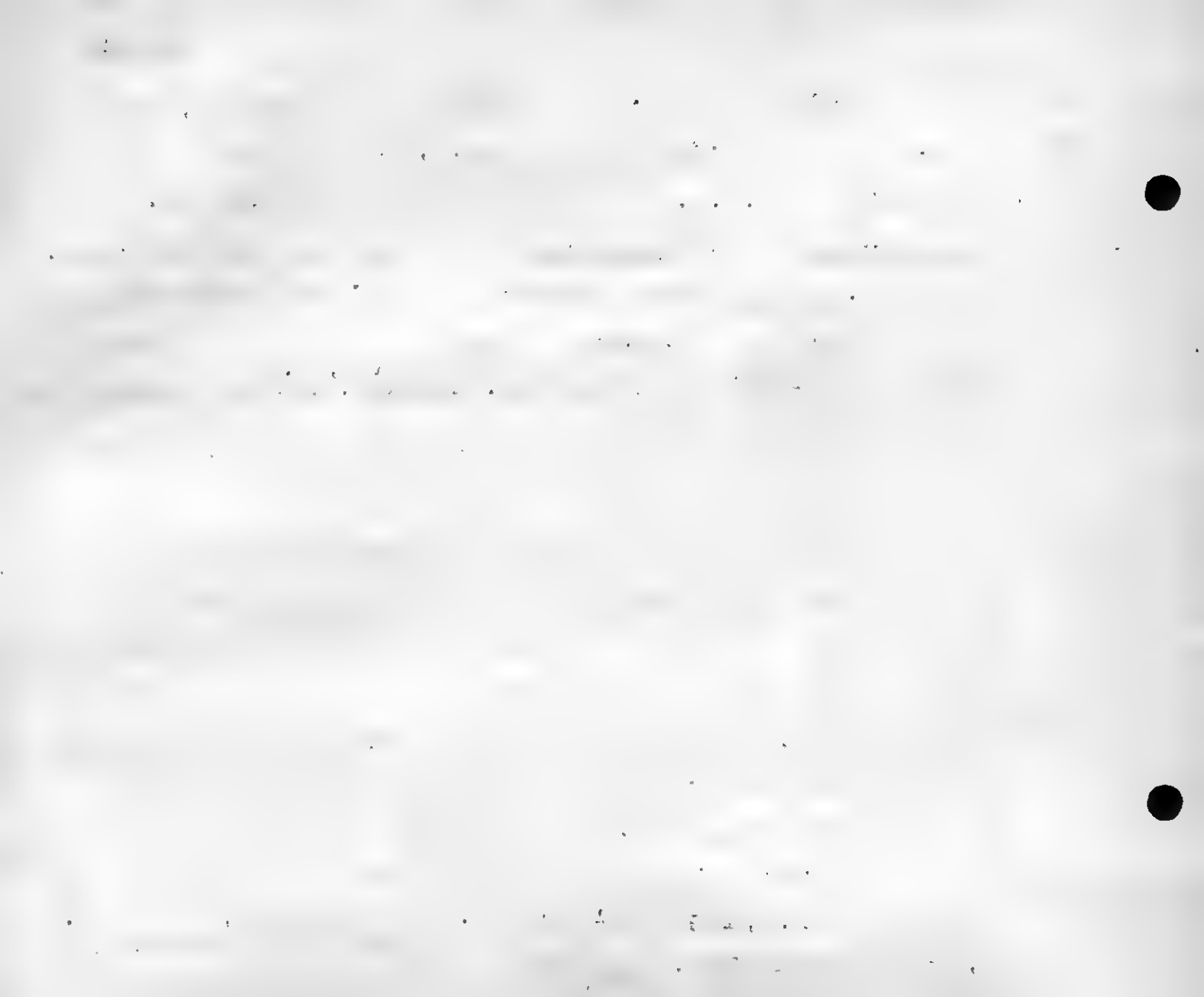
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
John			E.	Bruckman	Jan. 14, 1969			4:20 PM	
3 SEX	4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)	7. UNDER YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN
Male	White		11 March 1894			74 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		USA				Anne Arundel Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie, Md.			North Arundel			Waymaster - Retired		RR	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md.			AA		Glen Burnie		107 Main Avenue S. W.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Franklin D. Bruckman						Mary E. Ritchie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
no			171-07-8795		Mrs. Eloise Kellenberger, same as 13				
18. CAUSE OF DEATH (Enter an y one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-1-1967, to 1-16-1967, that (I) (we) last saw the deceased alive on 1-1-1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Herbert Mueller, M.D. DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-16-69	
22d. PHYSICIAN'S NAME (Type) Herbert Mueller, M. D.						22e. ADDRESS Parkton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		18 Jan. 69		Meadowridge Memorial		Blkridge, Howard, Md.			
24. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.						25a. REC'D BY REGISTRAR DATE JAN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23d Film 64-39 3/13/69 JP 00122											
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 <b>CERTIFICATE OF DEATH</b>											
1 DECEASED-NAME (Type or print) First Middle Last <b>Robert L. Brusberg</b>						2a DATE OF DEATH Month Day Year <b>January 31, 1969</b>			2b. HOUR M <b>11</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 5, 1924</b>		6 AGE (In years last birthday) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>45</b>		IF UNDER 24 HRS. HOURS MIN. <b>45</b>	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel Co.</b> Md					
10 CITY OR TOWN OF DEATH <b>North Linthicum</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>308 Regency Circle</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Electrician Fisher Body Car Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Linthicum</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>308 Regency Circle</b>											
14. FATHER'S NAME First Middle Last <b>Eldo Brusberg</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Alma Piaget</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1943-1946</b>				16b. SOCIAL SECURITY NO <b>233-24-7168</b>		17 INFORMANT <b>Linthicum, Md. Mrs. Elizabeth A. Brusberg 308 Regency Circle</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1579</u> <u>1579</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>July 24, '68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Adenocarcinoma Pancreas</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 24, 1968</u> to <u>Jan 31, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 31, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. Frederick Shipley MD</b>						22c. DATE SIGNED <b>February 2, 1969</b>		22d. PHYSICIAN'S NAME (Type) <b>E. Frederick Shipley MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 4, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beverly Hills Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Morgantown, W. Va. Md.</b>					
24. FUNERAL DIRECTOR <b>G. Truman Schwab 5151 Balto. National Pike Balto. Md.</b>						25a. RECD BY REGISTRAR <b>FEB 8 1969</b>		25b. OFFICIAL SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
3014 REV. 1-68

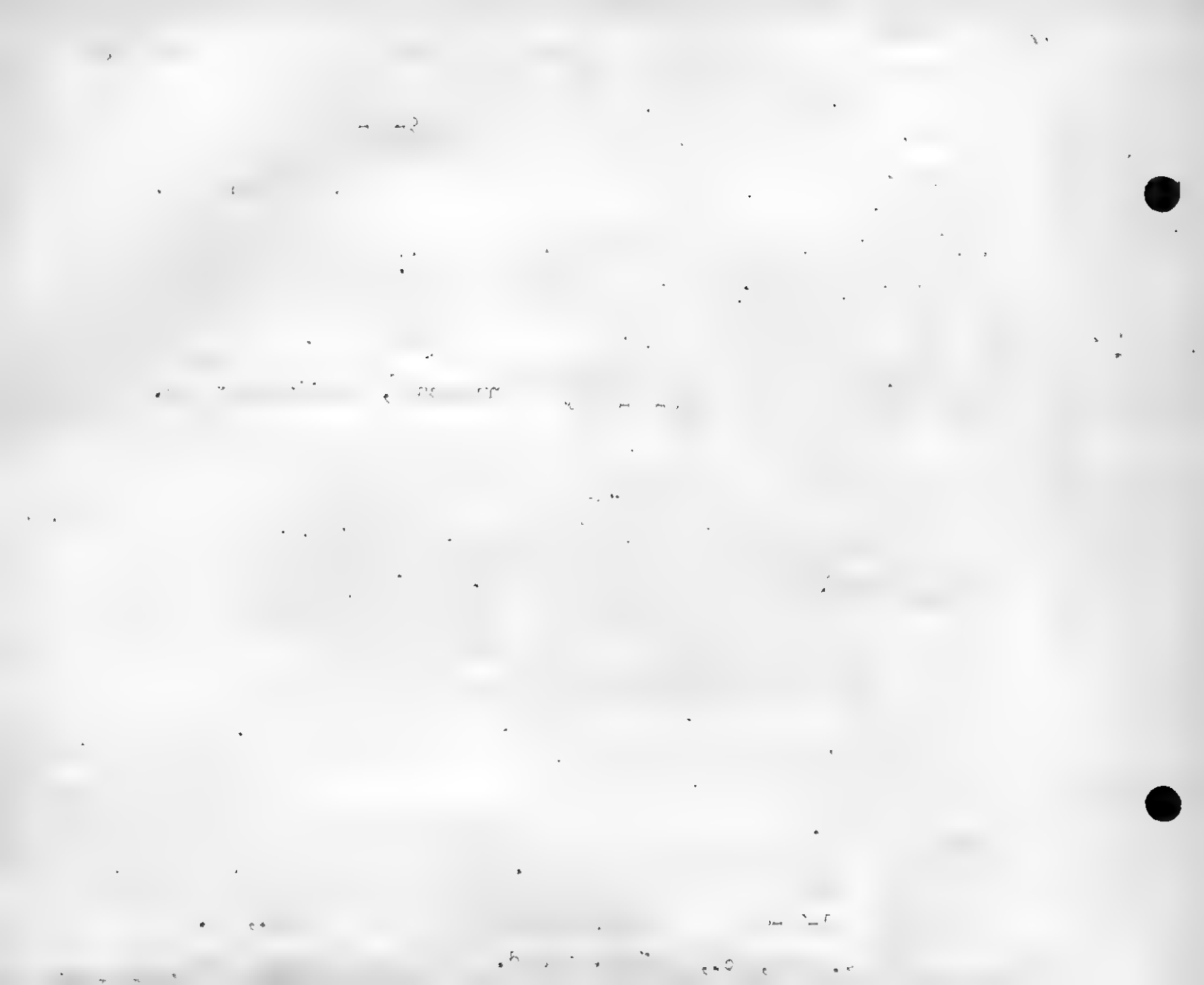
00122

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00123

1. DECEASED-NAME (Type or print) <b>Thomas</b>		First	Middle	Last	2a. DATE OF DEATH Month <b>Jan.</b> Day <b>18</b> Year <b>1969</b>		2b. HOUR <b>10:15</b> P.M.	
3. SEX <b>M</b>	4. RACE <b>W</b>		5. DATE OF BIRTH <b>9-27-88</b>		6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel A.A.</b>		
10. CITY OR TOWN OF DEATH <b>Crownsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CSH.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>foundry worker</b>		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>3802 Hamilton Ave Baltimore</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3802</b>		
14. FATHER'S NAME First Middle Last <b>Buczek</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>206-07-9158A</b>		17. INFORMANT <b>Ann Buczek</b>		Address <b>3802 Hamilton Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.V.A.</b> <b>4102</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>over 2 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Previous C.V.A. about 2 yrs ago</b>								
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>—</b>				
21f. LOCATION Street or R.F.D. No. City or Town County State <b>—</b>		22a. I certify that <b>AS</b> (this hospital) attended the deceased from <b>5/26</b> , 19 <b>68</b> , to <b>1/18</b> , 19 <b>69</b> , that <b>we</b> (we) last saw the deceased alive on <b>1/18</b> , 19 <b>69</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>we</b> (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Piyale Cerman</b>		DEGREE <b>—</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/19/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>PIYALE CERMAN</b>		22e. ADDRESS <b>CROWNDSVILLE STATE HOSP.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-21-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>				25a. REC'D BY REGISTRAR DATE <b>IAN 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



00124

1. DECEASED NAME (Type or print) <b>James</b>		2. RACE <b>White</b>		3. BIRTHPLACE (State or foreign country) <b>Maryland</b>		4. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		5. DATE OF BIRTH <b>July 13, 1925</b>		6. AGE (In years last birthday) <b>43</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
9. SEX <b>Male</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. COUNTY OF DEATH <b>Anne Arundel</b>		12. CITY OR TOWN OF DEATH <b>Annapolis</b>		13. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Dead on arrival Anne Arundel Gen. Hospital</b>		14. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		15. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		16. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>	
17. CITY OR TOWN <b>Annapolis</b>		18. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Dead on arrival Anne Arundel Gen. Hospital</b>		19. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		20. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		21. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		22. CITY OR TOWN <b>Annapolis</b>		23. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24. STREET AND NUMBER <b>510 Harbor Drive Hillsmere Shores</b>	
25. FATHER'S NAME First Middle Last <b>LAURENCE C. BULLEN</b>		26. MOTHER'S MAIDEN NAME First Middle Last <b>HATTIE A. VARTEN</b>		27. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or date of separation) <b>YES WWII-KR 219-12-3296</b>		28. SOCIAL SECURITY NO. <b>219-12-3296</b>		29. INFORMANT <b>Dorothy Ann Bulhen # 13</b>		30. ADDRESS <b># 13</b>		31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sudden death (Very sudden)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Known Severe Cor. Art. disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCD - Had 2 Coronaries past year</b>		32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 seconds</b> <b>1 1/2 years</b>	
33. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary Fall 1967; Coronary Fall Spring 1968</b>															
34. DATE OF OPERATION <b>1-10-69</b>		35. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ASCD</b>		36. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		37. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		38. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		39. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		40. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fall</b>		41. LOCATION Street or RFD No City or Town County State <b>Present</b>	
42. INJURY OCCURRED While <input type="checkbox"/> Mat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		43. PLACE OF INJURY (At home, farm, street, factory) (Office building, etc.) <b>At home</b>		44. LOCATION Street or RFD No City or Town County State <b>Present</b>		45. I certify that (I) (this hospital) attended the deceased from <b>Fall 1967</b> to <b>Present</b> , 19 <b>1969</b> , that (I) (we) saw the deceased alive on <b>1-10-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		46. SIGNATURE <b>Peter F. Verkouw M.D.</b>		47. DEGREE <b>M.D.</b>		48. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		49. DATE SIGNED <b>1-13-1969</b>	
50. BIRTHPLACE (State or foreign country) <b>Maryland</b>		51. DATE <b>1-15-69</b>		52. NAME OF CEMETERY OR CREMATORY <b>St Marys</b>		53. LOCATION (City or Town) (County) (State) <b>Annapolis D.A. MD.</b>		54. FUNERAL DIRECTOR <b>John M. Lottens Annapolis Md.</b>		55. REC'D BY REGISTRAR DATE <b>JAN 15 1969</b>		56. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		57. REGISTRAR'S NAME <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

00125

00125

1. PLACE OF DEATH a. COUNTY <b>Anne Arundle Co. Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dorsey</b> c. LENGTH OF STAY IN life <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Race Road Box #12 Hanover P.O.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundle</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dorsey</b> d. STREET ADDRESS <b>Race Road Box #12 Hanover P.O.</b>	
3. NAME OF DECEASED (Type or print) <b>Andrew Butler</b>		4. DATE OF DEATH Month Day Year <b>Jan 11, 19 69</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/17/1889</b>
9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR Months Days <b>79</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman- Ret</b>		12. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O Railroad</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Dorsey, Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Harry Butler</b>		16. MOTHER'S MAIDEN NAME <b>Rachel Burley</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>705-07-5885</b>	
19. INFORMANT <b>Mrs. Martha Butler Box #12 Hanover P.O.</b>		20. ADDRESS <b>Race Road</b>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <b>Cardio-vascular Disease</b> (b) DUE TO <b>Confirmites of age</b> (c) DUE TO <b>Blind for 24 years</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Interval between ONSET and DEATH 5 yrs</b>			
23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
26a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	26b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	26c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	26d. (City or town) (County) (State)
27. I certify that (1) (this hospital) attended the deceased from <b>11/4/68</b> to <b>1/11/69</b> that (2) (we) last saw the deceased alive on <b>1/11/69</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
28a. SIGNATURE <b>Dr. Bruce B. Brumbaugh</b>		28b. DATE SIGNED <b>1/14/69</b>	
29a. PHYSICIAN'S NAME (Type) <b>Dr. Bruce B. Brumbaugh</b>		29b. ADDRESS <b>5609 Main Street- Elkridge Maryland</b>	
30a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		30b. DATE THEREOF <b>1/15/69</b>	
31a. NAME OF CEMETERY OR CREMATORY <b>Saints Rest Cemetery</b>		31b. LOCATION (City, town or county) (State) <b>Harmons, Maryland</b>	
32. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert E. Nutter-3035 W. North Ave.</b>		33. REC'D BY REGISTRAR <b>JAN 21 1969</b>	
34. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

00126

00126

1. DECEASED NAME (Type or print) <b>Minty Snowden BUTLER</b>			2a. DATE OF DEATH Month <b>January</b> , Day <b>8</b> , Year <b>1969</b>		2b. HOUR P <b>1:05 M</b>
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>March 23, 1896</b>		6. AGE (In years last birthday) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Anne Arundel County</b>			10. CITY OR TOWN OF DEATH <b>Annapolis</b>		
11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Anne Arundel Gen. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired) <b>Scoutress</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY - N.Y.S.T. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>411 Chesapeake Avenue</b>
14. FATHER'S NAME First <b>Solomon</b> Middle <b>NIN</b> Last <b>Snowden</b>			15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Lucinda</b> Last <b>Priece</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>214-05-1660</b>		17. INFORMANT <b>Annapolis Md. Daisy Snowden-Harbour House Apts. 1155-apt 54</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left lower lobe Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the lungs with</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Melastoma to the brain</b> Cond trans, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R.L. Richardson</b>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>1/10/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Raymond L. Richardson, M. D.</b>		22e. ADDRESS <b>110 Clay Street, Annapolis, Maryland.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 11-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn - Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Annapolis, Maryland</b>					
24. FUNERAL DIRECTOR <b>C.E. Hicks 111 Annapolis, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 15 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

This mother is unwed and does not desire to name the baby. JBB

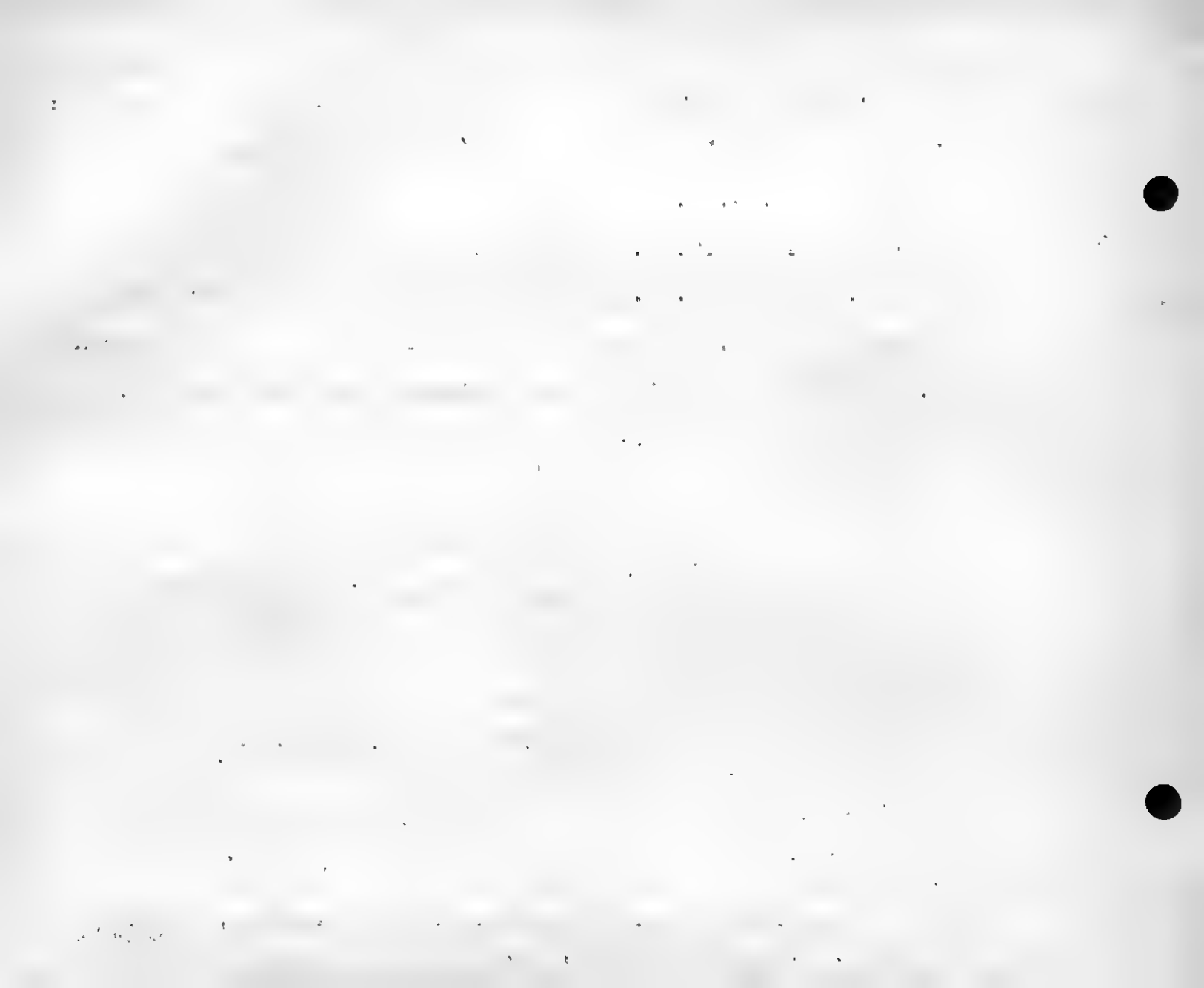
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR M
Raychele Denile Butler									January 29 1969			
3 SEX		4. RACE		5 DATE OF BIRTH				6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female		Negro		Jan. 29, 1969				YRS				0 30
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			10
Maryland			U.S.						Anne Arundel			MD
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis				Anne Arundel Gen. Hospital				Newborn				
13a. U.S. RESIDENCE (Where deceased lived, if institut an. Residence before admiss an) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland				Anne Arundel		Annapolis				1184 President St.		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last			
Robert Sylvester Wilson									Angela Denile Butler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT Address						
No			None			Hospital Records.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Premature Labor</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>the hospital</del> attended the deceased from <u>Jan. 29, 1969</u> to <u>Jan. 29, 1969</u> , that (I) <del>the</del> last saw the deceased alive on <u>Jan. 29, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.												
22b. SIGNATURE <u>Richard E. Cook</u>						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/30/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Richard E. Cook, M.D.</u>						22e. ADDRESS <u>20 Dean St., Annapolis, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			2-2-1969		Brewer Hill			Annapolis		A.A. Co Md		
24. FUNERAL DIRECTOR						ADDRESS			25a. REG. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C.E. Hicks, 111 Annapolis, Md									FEB 5 1969		<u>Richard E. Cook</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First <b>JAMES</b>			Middle <b>LOUIS</b>			Last <b>CAIN</b>		
2a. DATE OF DEATH			1			Month 20			Day 69		
2b. HOUR			6:45			P					
3. SEX		Male		4. RACE		White		5. DATE OF BIRTH		10/3/1914	
6. AGE (In years last birthday)		54		7. YRS				8. UNDER 1 YEAR		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country)		Maryland		7b. CITIZEN OF WHAT COUNTRY?		U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
										Anne Arundel Md.	
10. CITY OR TOWN OF DEATH			Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			D.O. A. North Arundel		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			Chauffeur			12b. KIND OF BUSINESS OR INDUSTRY			Taxi		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			Md.			13b. COUNTY			A. A.		
13c. CITY OR TOWN			Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
									1532 Tieman Drive		
14. FATHER'S NAME			First			Middle			Last		
			James			L.			Cain		
15. MOTHER'S MAIDEN NAME			First			Middle			Last		
			Clara						Pancoast		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give year or dates of service)			No.			16b. SOCIAL SECURITY NO.			17. INFORMANT		
						217 05 9994			Address		
									Millard Cain 1417 Rowe Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>											
4100 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Hypertensive Cordis vascular Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M.									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 6</u> , 19 <u>66</u> , to <u>Jan. 20</u> , 19 <u>69</u> , that (I) (we) saw the deceased alive on <u>Jan. 6</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		H. P. Friedman		40. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
								1/22/69			
22d. PHYSICIAN'S NAME (Type)		H. P. FRIEDMAN M.D.		22e. ADDRESS		1319 LIGHT ST. BALT. MD. 21230					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		1/23/69		Mt. Holly Cemetery		Onancock, Virginia					
24. FUNERAL DIRECTOR		Raymond C. Fink		Glen Burnie, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DATE		JAN 23 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Charles Otis CARROLL						January 28 1969			6:00 M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male	Negro		July 3, 1884			84 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland			U.S.				Anne Arundel Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life or ever if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel Gen. Hospital			Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY, J.M.T?		13e. STREET AND NUMBER
Maryland			Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		156 Bestgate Road
14. FATHER'S NAME First Middle Last			15. MOTHER'S M.A.D.N. NAME First Middle Last						
Franklin Carroll			Elizabeth Carroll						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
					Charles Carroll Wash. D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage (V.A.)									
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive H.C.I.D.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from Jan 27, 1969, to Jan 28, 1969, that (I) (we) lost saw the deceased alive on Jan 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
Peter F. Verkouw MD									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22c. DATE SIGNED			
PETER F. VERKOUW			1407 Forest Drive, Annapolis, Md.			1-29-1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2-1-1969		Fowlers		Chesapeake City, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
William Reese			Chesapeake City, Md.			FEB 3 1969		Charles Judge	



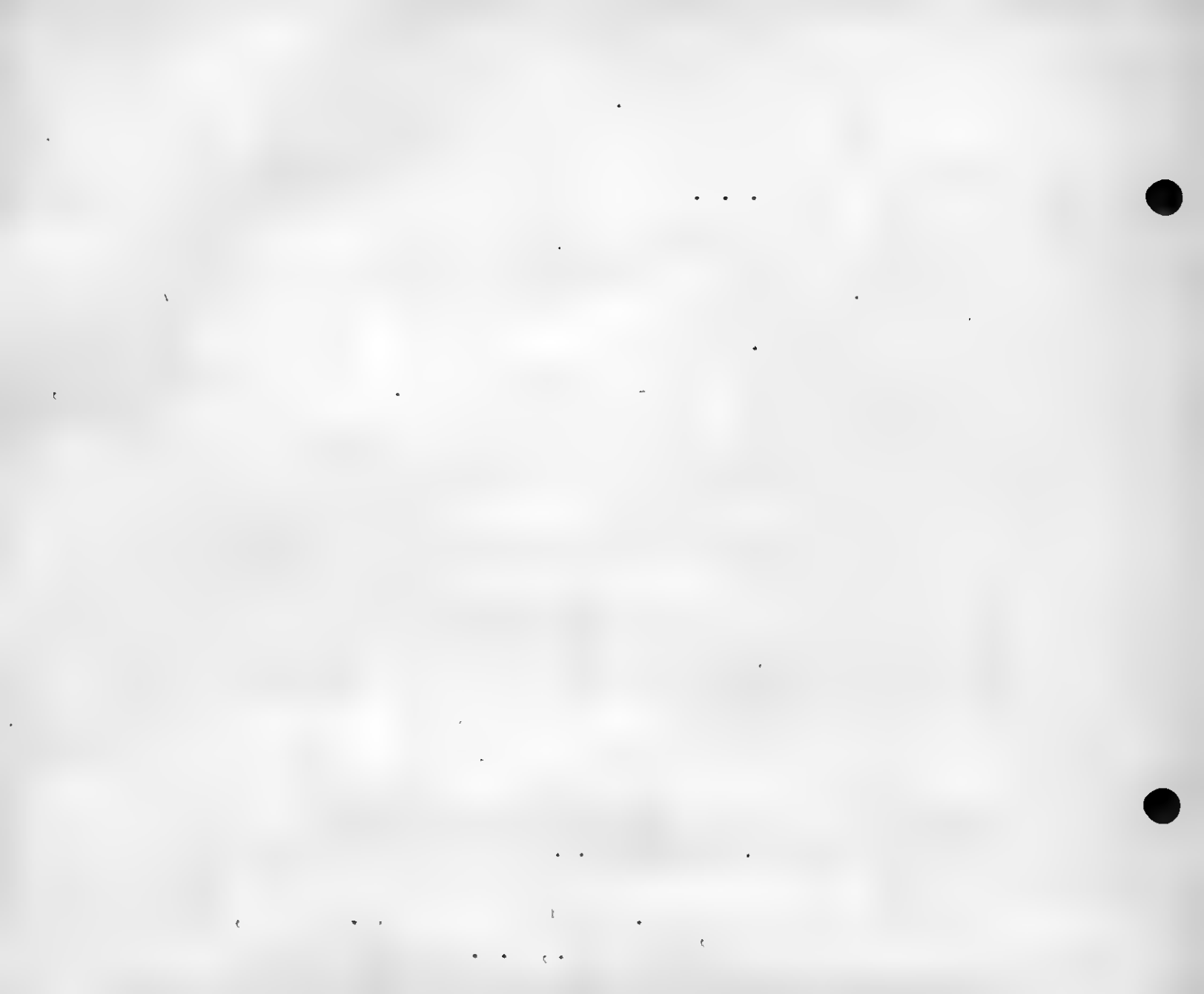
FOR STATE  
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
WALLACE			E.			CARROLL			1/26 19 69 M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Male	Negro	5/26/34	34 YRS					January 26, 19 69			1:30 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U.S.A.				Anne Arundel Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital have street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel Gen. Hospital								
13a. USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Md.			Prince Georges			Upper Marlboro			General Delivery		
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
James R. Carroll				Essie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
				215-30-6460		James R. Carroll Box 3384 Upper Marlboro, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of thorax											
365X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a):											
storing the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			12:00 midnight 1/26 19 69			?					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
		Parking Lot		River Bend Inn		Lothian		Anne Arundel		Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
										January 27, 1969	
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		2-1-69		St. Mary's Church Ceme.		Croom, Maryland					
24. FUNERAL DIRECTOR'S NAME		Address		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Rollins Funeral Home, Inc.		4339 Hunt Pl., N.E.		DATE JAN 30 1969		Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00131

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00131

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 1 24 69			2b. HOUR A M		
3 SEX M			4 RACE W	5 DATE OF BIRTH 11-13-14		6 AGE (n years last birthday) 54 YRS	7 UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 1 Day 24 Year 69	2d. HOUR A M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH A.A.CO			Md	
10 CITY OR TOWN OF DEATH New Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOP-NORTH ARONDEL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Green Gables Rt 1 Box 110			
14 FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS			
Yes			WW 2		215-07-4982			Mrs Mary E. Cassel Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Protracted</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 1-24-69 A.A.CO.					
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1/28/69			Baltimore National			Baltimore Co, Md.		
24. FUNERAL DIRECTOR			Balt Md. 21228			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks West Inc 6212 Balt. Nat			Fm			JAN 31 1969			[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4/14/69  
30M REV 1-69

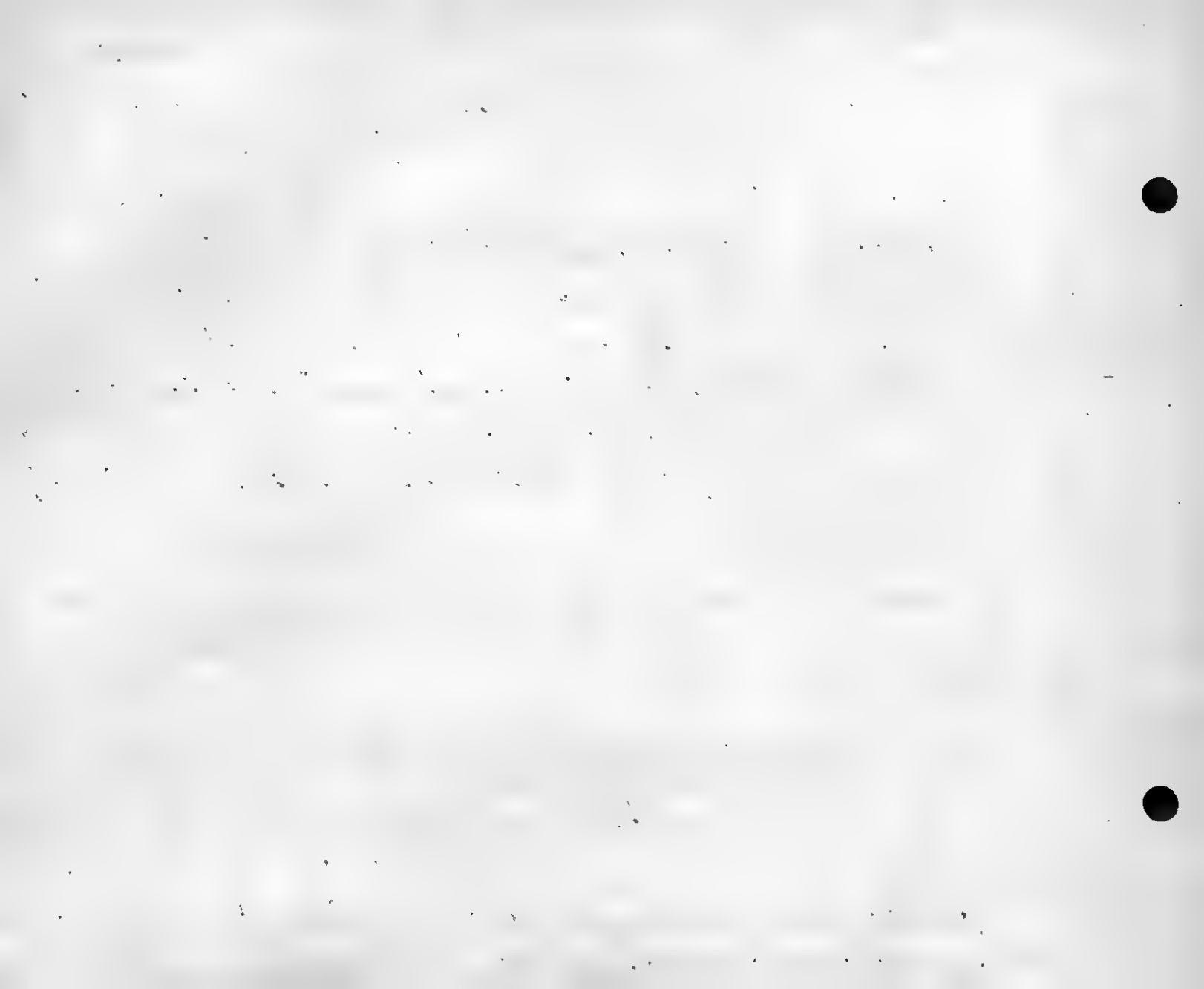
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="text-align: center;"> <div>00132</div> <div>CERTIFICATE OF DEATH</div> <div>00132</div> </div>										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Freida E. Cathcart						Month Day Year Jan 24 1969		P M 7:15		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		11-24-04		64 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			North Arundel			Housewife		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, JIM TSP?		13e. STREET AND NUMBER	
Md.			AA		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8430 Church Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Henry Hansel			First Middle Last Anna Mendel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT					
No			218-23-6711		Mrs. Glenda Klauzowski -1704 Lansing Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Extensive Tracheobronchitis</i>									Days	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
<i>Moderately severe obstructive pulmonary disease</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION		Street or R.F.D. No		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										
22a. I certify that (I) (this hospital) attended the deceased from _____, 1969, to 1-24, 1969, that (I) (we) lost the deceased alive on 1-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
<i>Glenn M. [Signature]</i>								1-24-69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
				N. Arundel Hosp/						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Jan. 27, 1969		Glen Haven Mem. Pk.		Glen Burnie, Maryland				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George J. Gonco				1071 Ritchie Hwy.		JAN 29 1969		<i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
CAROLINE V. CHANEY						Jan 10 1969			4:10 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
F		Caucasian		4/21/1888		80 YRS.		MONTHS DAYS		HOURS M. N.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			U.S.A.			Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
ANNAPOLIS			ANNAPOLIS NURSING HOME			HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD			A.A. Co ANNAPOLIS			ANNAPOLIS			311 WASHINGTON ST.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
J B OGDEN			JULIA COLLISON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			022408789J			MR. HOWARD T. CHANEY #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4124 Cerebral Thrombosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardiovascular disease										2 days	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of colon											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year 19 P.M.								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 9, 1969, to Jan 10, 1969, that (I) (we) last saw the deceased alive on Jan 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED		
Ray M. Smith			Ray M. Smith			HARRIS PROF. BLDG SUBURBAN PK MD.			Jan 10 1969		
23a. BURIAL, CREMATION			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Buried			1/12/1969			CEDAR BLUFF CEM.			ANNAPOLIS A.A. Co MD.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
JOHN M. TAYLOR - SONS ANNAPOLIS MD.			DATE JAN 14 1969			James J. Jones					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00134

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
JAMES E. CHESNUTT						19			M
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
male	negro	March 28, 1930	38 YRS.					January 19, 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Conway S.C.		USA				Anne Arundel Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel General Hosp.						
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis			604 Lreams Landing	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Sunny Chestnut			Mahalia Stanley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT ADDRESS				
					Lalmer J. Home		B.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stabwound of Neck</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:00 P.M. 1/19 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) subj. stabbed in neck by wife				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) parking lot		21f. LOCATION Street or R.F.D. No City or Town County State		Annapolis, Anne Arundel, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Werner U. Spitz</u>			EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 1/19/69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-30-69		South Carolina		Conway South Carolina			
24. FUNERAL DIRECTOR ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Lalmer J. Home			DATE JAN 31 1969		Charles Judge				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP  
45M

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
00135												
CERTIFICATE OF DEATH												
00135												
1 DECEASED-NAME (Type or print)			First Kathleen		Middle P.		Last CHITTY		2a. DATE OF DEATH Month 7, Day 1969		2b. HOUR 9:25 M	
3 SEX Female		4. RACE White			5. DATE OF BIRTH October 7, 1892			6 AGE (In years last birthday) 76 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) England		7b CITIZEN OF WHAT COUNTRY? ENGLAND			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.					
10 CITY OR TOWN OF DEATH Annapolis			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY 13b COUNTY		13c CITY OR TOWN Anne Arundel Mayo		13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 301 Maple Street, Beverly Beach,			
14 FATHER'S NAME First Middle Last UNKNOWN			15 MOTHER'S MAIDEN NAME First Middle Last UNKNOWN									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			16b SOCIAL SECURITY NO 579-48 9112			17 INFORMANT AGNES P. WILLIS Address 3100 MASS. AVE., N.W. WASHINGTON, D.C.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4569 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus Fractured Ankle</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State								
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 1969, that (I) (we) last saw the deceased alive on _____, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Richard I. Hochman, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED 1/8/69				
22d PHYSICIAN'S NAME (Type) Richard I. Hochman, M. D.				22e ADDRESS 16 Murray Avenue, Annapolis, Maryland.								
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE Jan 15 1969		23c NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		23d LOCATION (City or Town) (County) (State) COLMAR MARSH PRINCE GEORGES MD.						
24 FUNERAL DIRECTOR W.W. CHAMBERS CO. INC.				ADDRESS WASHINGTON, D.C.		25a REC'D BY REGISTRAR DATE JAN 16 1969		25b REGISTRAR'S SIGNATURE John J. Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)			First <b>Katherine</b>		Middle <b>B.</b>		Last <b>Coe</b>		2a. DATE OF DEATH <b>1</b> Month <b>16</b> Day <b>69</b> year		2b. HOUR <b>2A</b> M		
3. SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>6-5-04</b>			6. AGE (In years lost birthday) <b>64</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>A.A.Co.</b>				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission, STATE) <b>Maryland</b>			13b. CITY OR TOWN <b>Balto. County</b>			13c. INSIDE CITY, J.M. IS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER <b>2540 Virginia Ave.</b>				
14. FATHER'S NAME First <b>James</b>			Middle <b>Taylor</b>			Last <b>Elmira</b>			15. MOTHER'S MAIDEN NAME First <b>Thompson</b>			Middle <b>Thompson</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>William I. Coe, same as 13</b>			Address				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Mitral Valve Disease - possibly Rheumatic</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>12-24, 1968</b> , to <b>1-16-1969</b> , that (I) (we) last saw the deceased a. ve on <b>1-15-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Hilary T. O'Herlihy M.D.</b>						22c. DATE SIGNED <b>1-16-69</b>							
22d. PHYSICIAN'S NAME (Type) <b>Hilary T. O'Herlihy M.D.</b>						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>20 Jan. 69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>			23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, AA, Md</b>				
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>						25a. REC'D BY REGISTRAR <b>JAN 17 1969</b>			25b. RECEIVED BY STATE DEPT. OF HEALTH <b>James Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #8, Film 3410 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
I enc. Film 3410 3/7/69 kk 0013

# CERTIFICATE OF DEATH

01837

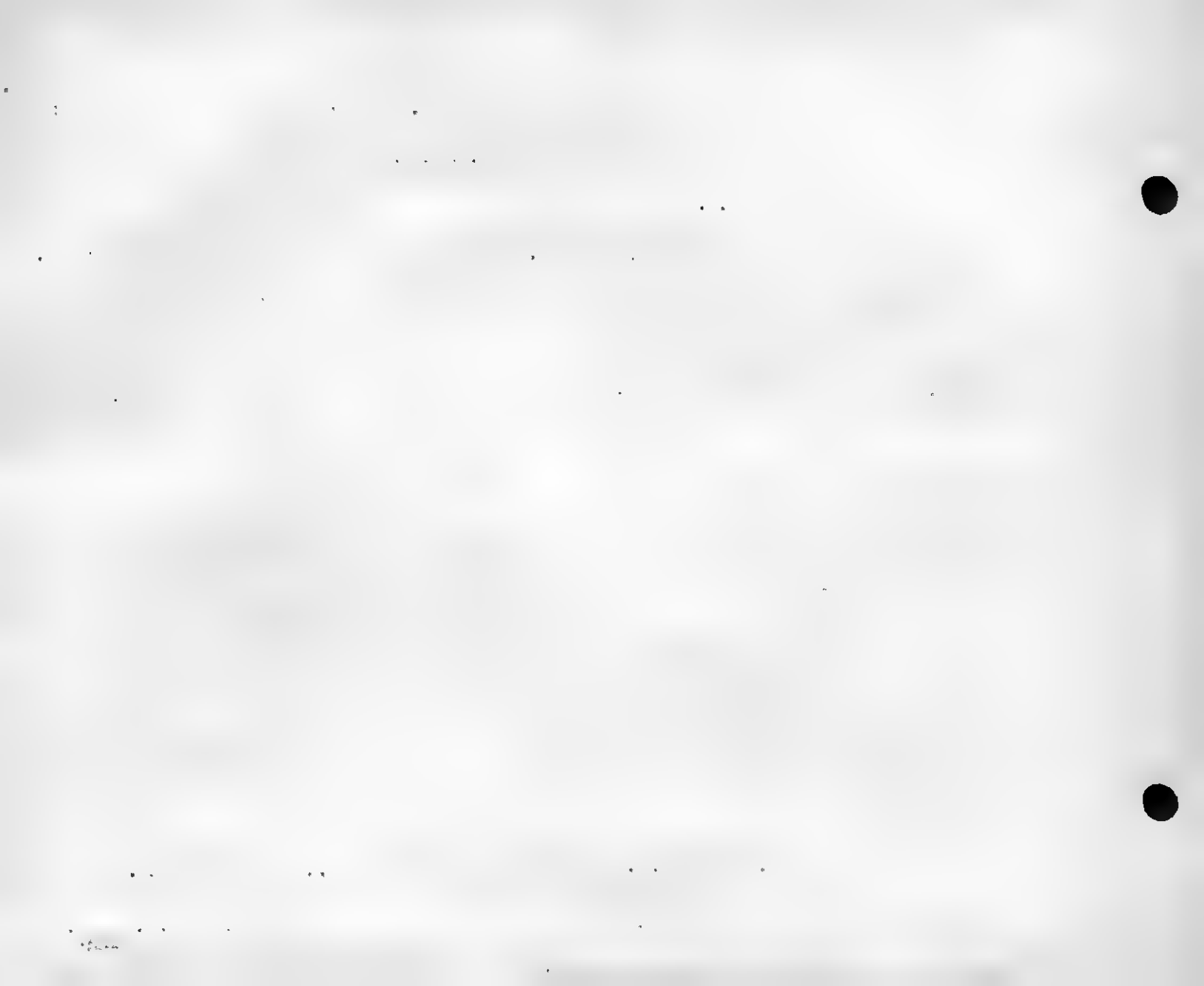
1. DECEASED NAME (Type or print) <b>Courtney</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>24</b> Year <b>69</b>			2b. HOUR <b>7:25a</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8/8/04</b>		6. AGE (In years last birthday) <b>65</b> YRS		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>unknown</b>			7b. CITIZEN OF WHAT COUNTRY? <b>US</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Anne Arundel</b>				
10. CITY OR TOWN OF DEATH <b>Crownsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Crownsville State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>unknown</b>	
14. FATHER'S NAME First Middle Last <b>unknown</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>unknown</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>unknown</b>			16b. SOCIAL SECURITY NO. <b>unknown</b>			17. INFORMANT Address <b>Hospital Records, Crownsville, Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>Pneumonia</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <b>Arteriosclerotic cardio vascular disease</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
<b>Pulmonary T.B. (?) Chronic brain syndrome</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>68</b> , to <b>1/24</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/24</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Charles R. Venter, M.D.</b>			22c. DATE SIGNED <b>1/24/69</b>			22d. PHYSICIAN'S NAME (Type) <b>Charles R. Venter, M.D.</b>			22e. ADDRESS <b>X Crownsville State Hospital, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>2-24-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Univ. Md. Med. School</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR <b>FEB 28 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00136 CERTIFICATE OF DEATH 00137										
1 DECEASED NAME (Type or print)			First Middle Last		2a. DATE OF DEATH Month Day Year			2b. HOUR M		
Henry Becker			COOKE, Sr.		January 12 1969			1:00		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		
Male		White		Feb. 20, 1884		84 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.				Anne Arundel				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel Gen. Hospital			grocer		self empl.		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS. DE CITY LHM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Anne Arundel		Gambrills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		---	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Augustus Gambrill Cooke			Unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address					
No.			137-05-6231		Mary Cooke Sands - same as #13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from <u>15 MAY, 1968</u> , to <u>12 JAN, 1969</u> , that (1) (we) last saw the deceased alive on <u>12 JAN 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Edward S. Beck</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>1-13-69</u>			
22d PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.					22e ADDRESS 73 Franklin St., Annapolis, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		1/14/69		St. Stephens Cemetery		millersville 4.4 Md.				
24. FUNERAL DIRECTOR'S ADDRESS <u>Burial &amp; Home</u>					25a REC'D BY REG STRIP DATE <u>JAN 15 1969</u>		25b REGISTRATION <u>James J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

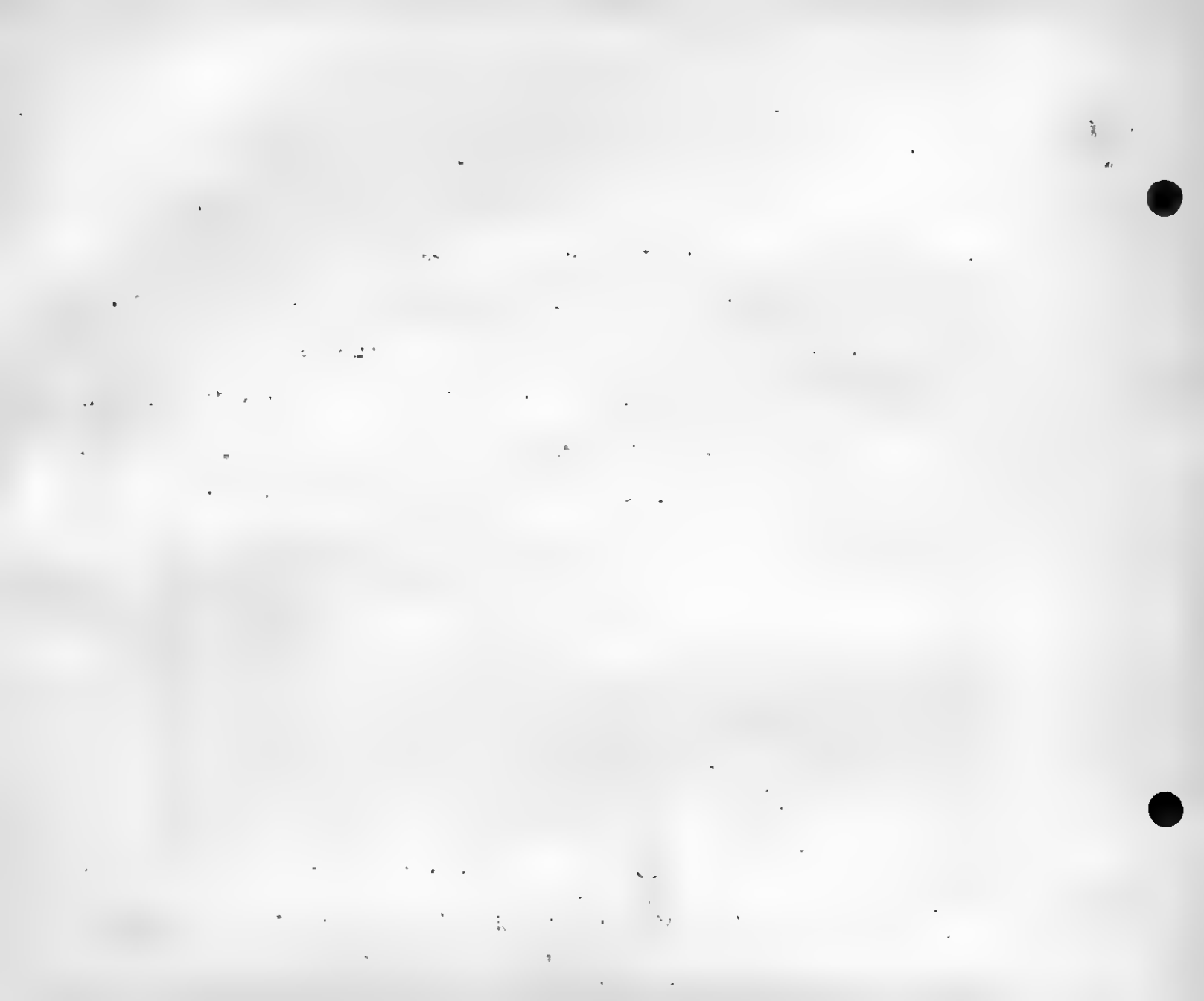
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR					
Joseph			F.		Cousler		1 = 31 69			7:30a M							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.			
Male			White			9/29/24			74 1/2 YRS.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH								
Maryland			US A						Anne Arundel				Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
Crownsville			Crownsville State Hospital			Fireman Patapsco & Back River RR											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Balto			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			315 Kresson Street					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
James							Cousler		Margaret							Bruner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address								
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service)			216-16-8457			Hospital Records, Crownsville, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Severe acute pulmonary edema, congestion and</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) <u>focal atelectasis</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <u>Tracheo-bronchial aspiration of gastric content</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
<u>chronic brain syndrome. Focal pneumonia; dilation of stomach</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>6/28, 19 65</u> to <u>1/31, 19 69</u> , that (I) (we) last saw the deceased alive on <u>1/31, 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			Charles R. Venter, M.D.			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
												2/3/69					
22d. PHYSICIAN'S NAME (Type)			Charles R. Venter, M.D.			22e. ADDRESS			Crownsville State Hospital, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
Burial			2/5/69			Balto. National Cemetery			Baltimore, Maryland								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
John J. Duda, 7922 Wise Ave. Dundalk, Md.						FEB 5 1969			Charles Judge								



TO TUNIKAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-5 (1)  
FORM REV. 7-68

00140										MAY 1969										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00139																			
Items: 6824; Film: 109 1/29/69 kk										CERTIFICATE OF DEATH																																							
1 DECEASED NAME (Type or print) First Middle Last Frank Dawson										2a DATE OF DEATH Month Day Year 1 24 69										2b HOUR 7:15 AM																													
3 SEX Male										4 RACE White										5 DATE OF BIRTH 6/14/94										6 AGE (In years last birthday) 71 7/7 YRS										7b IF UNDER 24 HRS MONTHS DAYS HOURS MIN									
7a BIRTHPLACE (State or foreign country) Maryland										7b CITIZEN OF WHAT COUNTRY? US										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Anne Arundel Md.																			
10 CITY OR TOWN OF DEATH Crownsville										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md										13b COUNTY Balto										13c CITY OR TOWN Baltimore										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 31 West Preston Street									
14 FATHER'S NAME First Middle Last Abraham Dawson										15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Kedge																																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no										16b SOCIAL SECURITY NO 214-05-6208										17 INFORMANT Hospital Records, Crownsville, Maryland										Address																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiovascular disease, Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Malnutrition</u>																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																	
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION Street or R.F.D. No. City or Town County State																													
22a I certify that (I) (this hospital) attended the deceased from 12/21, 1968, to 1/24, 1969, that (I) (we) last saw the deceased alive on 1/20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b SIGNATURE <i>Ally G. Galtz</i>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c DATE SIGNED 1/24/69																													
22d PHYSICIAN'S NAME (Type) <i>Ally G. Galtz</i>										22e ADDRESS Crownsville State Hospital, Maryland																																							
23a BURIAL, CREMATION, REMOVAL (Specify) REMOVAL										23b DATE 1-27-69										23c NAME OF CEMETERY OR CREMATORY Md. Med. School										23d LOCATION (City or Town) (County) (State) Baltimore Md.																			
24 FUNERAL DIRECTOR WILLIAM REESE										25a ADDRESS 108 W. Washington St. Baltimore, Md.										25b REGISTRAR'S SIGNATURE JAN 28 1969										DATE																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 11 Film 499 2/13/69 kk									
1 DECEASED-NAME (Type or print) <b>MARY Louise DIXON</b>					2a. DATE OF DEATH Month <b>JAN</b> Day <b>29</b> Year <b>1969</b>		2b. HOUR M		
3 SEX <b>Female</b>		4 RACE <b>white</b>		5. DATE OF BIRTH <b>MAY 4, 1927</b>		6 AGE (In years last birthday) <b>41</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>WASH, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ANNE ARUNDEL Co</b> Md			
10. CITY OR TOWN OF DEATH <b>Edgewater</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rte. 3, Box 3F</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>WAITRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CAFETERIA</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md</b>		13b. COUNTY <b>AA Co</b>		13c. CITY OR TOWN <b>Edgewater</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rte 3 Box 3F</b>	
14 FATHER'S NAME First <b>Charles J.</b> Middle <b>L</b> Last <b>LENTZ</b>		15 MOTHER'S MAIDEN NAME First <b>Magdeline</b> Middle <b>M</b> Last <b>MAHONEY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <b>228-30-4622</b>		17. INFORMANT <b>Curtis Dye</b>		Address <b>Edgewater, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <b>Myocardial Failure</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchial Asthma</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Obesity</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Undetermined</b>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Since Childhood</b>									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1963</b> , to <b>Jan 1969</b> , that (I) (we) last saw the deceased alive on <b>1-18-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE <b>W. P. Stephens M.D.</b>		22c. DATE SIGNED <b>1-30-69</b>		22d. PHYSICIAN'S NAME (Type) <b>William STEPHENS M.D.</b>					
22e. ADDRESS <b>Cornhill St. Annapolis, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb 1, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beulah BAPTIST</b>		23d. LOCATION (City or Town) (County) (State) <b>FRANCONIA VA</b>			
24. FUNERAL DIRECTOR <b>Hardesty Funeral Home, Annapolis, Md</b>					25a. REC'D BY REGISTRAR <b>FEB 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>Thomas Dodson</b>						2a. DATE OF DEATH JAN • Month 25 Day 1969 Year			2b. HOUR 11:45 A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8/17/91		6. AGE (In years last birthday) 78 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7b. BIRTHPLACE (State or foreign country) unknown		7c. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md					
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. US J.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Balto		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 839 S. Bond Street		
14. FATHER'S NAME First Middle Last unknown				15. MOTHER'S MAIDEN NAME First Middle Last unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) unknown				16b. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, Crownsville State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (c) Lt hip fracture. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic cardiovascular disease. Pulmonary embolism.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 10/3, 19 68, to 1/25, 19 69, that (I) (we) last saw the deceased alive on 1/25, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE NICK P. MOUTSOR						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/25/69			
22d. PHYSICIAN'S NAME (Type) NICK P. MOUTSOR		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2.24.69		23c. NAME OF CEMETERY OR CREMATORY C. of Md. Med. Schol		23d. LOCATION (City or Town) Baltimore Md		(County)		(State)	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 28 1969		25b. REGISTRAR'S SIGNATURE Maurice J. J.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, add "and 2" should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

00141

00141

1 DECEASED-NAME (Type or print) <b>ETHEL MARIE DORSEY</b>			2a. DATE OF DEATH Month <b>Jan</b> Day <b>7</b> Year <b>1969</b>			2b. HOUR <b>11:00 P M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>MAR 24 1906</b>		6. AGE (In years last birthday) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.				
10. CITY OR TOWN OF DEATH <b>Tracy's Landing</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Tracy's Landing</b>			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Tracy's Landing</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <b>Clarence</b> Middle <b>Phillips</b> Last <b>Deila</b>			15. MOTHER'S MAIDEN NAME First <b>Deila</b> Middle <b>OSTHERTON</b> Last <b>OSTHERTON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b. SOCIAL SECURITY NO <b>1</b>			17. INFORMANT <b>Dorothy Dempsey Arnold, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> , 19 <b>61</b> , to <b>Jan 7</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Jan 7</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Willard F. Smith</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/9/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>Willard F. Smith</b>				22e. ADDRESS <b>Shady Side, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-10-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT Harmony</b>		23d. LOCAT ON (City or Town) (County) (State) <b>MT Harmony, Md.</b>				
24. FUNERAL DIRECTOR <b>Bernard Hardesty Hidesville Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>PATRICK DORSEY</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>1</b> Day <b>1</b> Year <b>1969</b>			2b. HOUR <b>1 a.m.</b>			
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>5 June 1950</b>	6 AGE (in years last birthday) <b>18</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>1</b> Year <b>1969</b>			2d. HOUR <b>1 a.m.</b>
7a. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIM. IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1305 Catwood Road</b>
4. FATHER'S NAME First <b>Francis</b> Middle <b>O.</b> Last <b>Dorsey</b>			15. MOTHER'S MAIDEN NAME First <b>Elda</b> Middle <b>H.</b> Last <b>Johnson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Father - same as 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: <b>15.0</b> IMMEDIATE CAUSE (a) <b>Injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>12 xx 1 1 1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Driver in auto-fixed object coll.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>		21f. LOCATION Street or R.F.D. No <b>Entrance Fort Smallwood Pk.</b> City or Town <b>A. A.</b> County <b>Md.</b> State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Edward F. Wilson</b>			EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>1/1/69</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>4 Jan. 69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady Of Sorrows Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Owensville, AA, Md.</b>		
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>			ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 155  
30M REC 100

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00144

00143

1. DECEASED-NAME (Type or print) Roy V Dudley			2a. DATE OF DEATH January 25 1969			2b. HOUR 9:40 PM						
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-30-17		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.						
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1220 Crawford Dr.			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Construction Foreman McLean Corp.			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIM. TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1220 Crawford Drive			
14. FATHER'S NAME First Middle Last Roy V. Dudley Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Janie Knight									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Mary K. Dudley (wife) Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarct 411/1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) at main coronary occlusion (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from July 11, 1966, to JAN 13, 1969, that (I) (we) lost saw the deceased alive on JAN 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE Leon C. Perry MD.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 1-26-69			
22d. PHYSICIAN'S NAME (Type) Leon C. Perry MD						22e. ADDRESS Glen Burnie, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan. 28 1969			23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park Glen Burnie, Maryland			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR E.B. Flannery			ADDRESS Singleton Funeral Home Glen Burnie, Md.			25a. REC'D BY REG STRAR JAN 30 1969			25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and send 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00144												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00144											
Item 23 Filed 09 2/10/69 kk												CERTIFICATE OF DEATH																							
1 DECEASED NAME (Type or print) <b>LAWRENCE</b>				First Middle Last				2a DATE OF DEATH <b>JAN</b> Month <b>02</b> Day <b>1969</b> Year				2b. HOUR <b>9:00</b> M																							
3. SEX <b>Male</b>				4 RACE <b>Negro</b>				5 DATE OF BIRTH <b>20 June 1946</b>				6. AGE (In years last birthday) <b>22</b> YRS				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN															
7a BIRTHPLACE (State or foreign country) <b>Mississippi</b>				7b CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <b>Anne Arundel</b>				Md																			
10 CITY OR TOWN OF DEATH <b>Fort George G. Meade</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>U.S. Kimbrough Army Hosp</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Serviceman</b>				12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>																							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Delaware</b>				13b. COUNTY <b>Kent</b>				13c CITY OR TOWN <b>Frederica</b>				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER <b>201 Thomas</b>																			
14 FATHER'S NAME <b>Olin</b>				First Middle Last <b>Singleton</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Catherine F. Neal</b>																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>Yes 1964-1968</b>				16b. SOCIAL SECURITY NO. <b>222-28-9668</b>				17 INFORMANT <b>201 Thomas, Frederica, Delaware</b> <b>Catherine F. Neal (mother)</b>																											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Primary Myocardial Disease</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>																							
428X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (a) (this hospital) attended the deceased from <b>14 Jan</b> , 19 <b>69</b> , to <b>22 Jan</b> , 19 <b>69</b> , that (b) (we) last saw the deceased alive on <b>22 Jan</b> , 19 <b>69</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above; (d) (we) (did) (not) view the body after death.																																			
22b SIGNATURE <b>John J. Rothschild</b>				DEGREE <b>CPT, MC</b>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c DATE SIGNED <b>22 Jan 1969</b>																							
22d. PHYSICIAN'S NAME (Type) <b>JOHN J. ROTHSCHILD, CPT, MC</b>				22e ADDRESS <b>U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD</b>																															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b DATE <b>1-28-69</b>				23c NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>				23d LOCATION (City or Town) (County) (State) <b>Cimelon</b>																							
24. FUNERAL DIRECTOR <b>Benny W. Peck</b>				ADDRESS <b>1000 E. 1st St.</b>				25a. RECEIVED BY REGISTRAR <b>FEB 4 1969</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																							

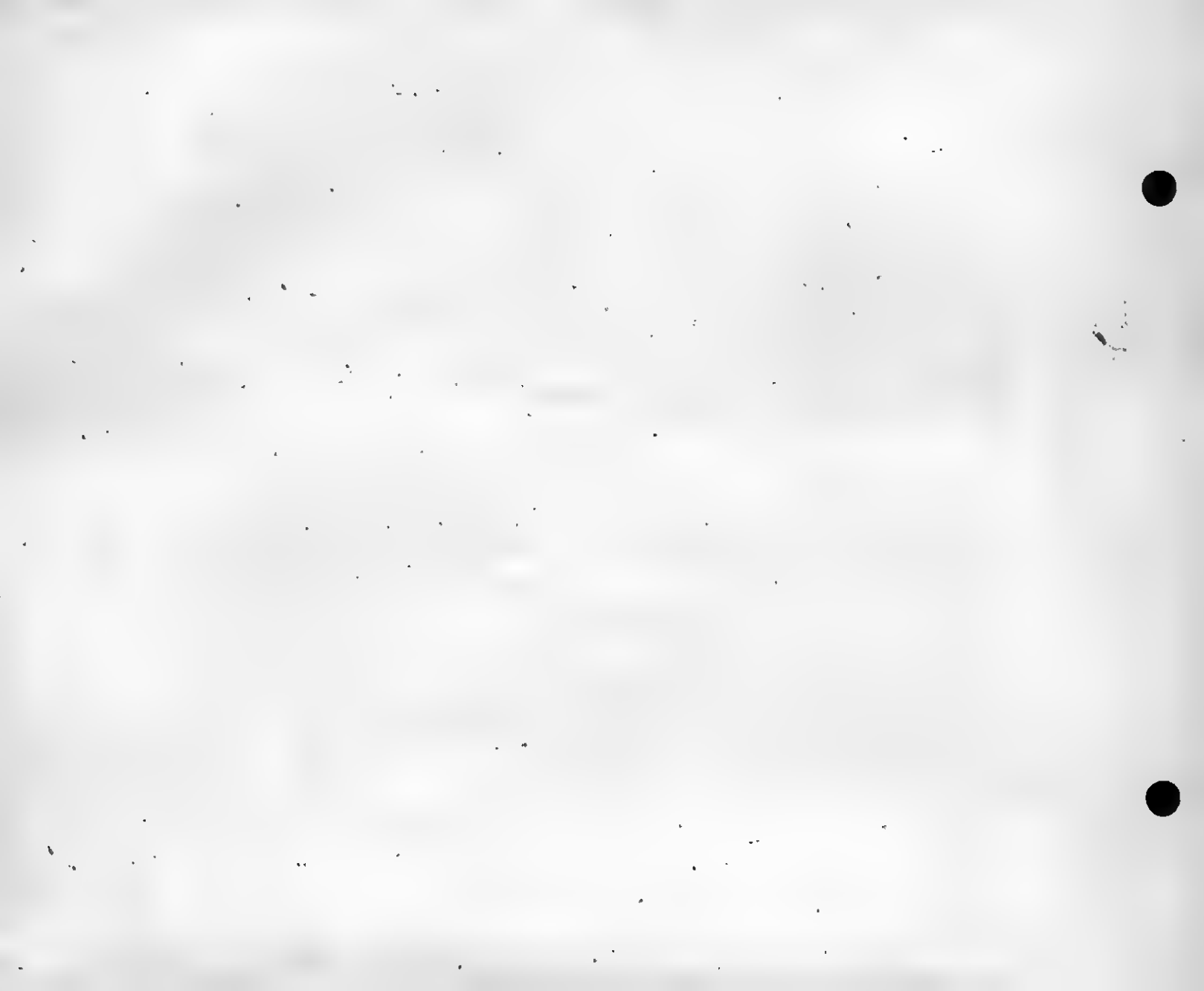
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Louis</i>		First <i>Louis</i>		Middle <i>EBERLING</i>		Last <i>EBERLING</i>		2a. DATE OF DEATH Month <i>January</i> Day <i>17</i> Year <i>1969</i>		2b. HOUR M
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>June 5<sup>th</sup>, 1885</i>		6. AGE (in years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i>				Md
10. CITY OR TOWN OF DEATH <i>Crownsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Crownsville State Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>STEEL</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. since before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2211 McElderry Street</i>		
14. FATHER'S NAME First <i>George</i> Middle <i>Eberling</i> Last <i>?</i>		15. MOTHER'S MAIDEN NAME First <i>Marie</i> Middle <i>?</i> Last <i>?</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-057629</i>		17. INFORMANT <i>Medical Records - Crownsville State Hospital</i>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonitis</i>										<i>4 days</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Subarachnoid Hemorrhage.</i>										<i>1 wk</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular Disease.</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Dehydration and Uremia with Decubitus Ulcers</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No <i>April 12<sup>th</sup>, 1966</i>		City or Town <i>16</i>		County <i>St</i>		State
22a. I certify that (I) (this hospital) attended the deceased from <i>April 11<sup>th</sup>, 1966</i> , to <i>January 17, 1969</i> , that (I) (we) lost saw the deceased alive on <i>January 17<sup>th</sup>, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edward Henry Math M.D.</i>		22c. DATE SIGNED <i>January 17, 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>Lionel McHenry M.D.</i>		22e. ADDRESS <i>Crownsville State Hospital, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>1-21-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN CEM.</i>		23d. LOCATION (City or Town) <i>BALTO., Md.</i>		(County)		(State)
24. FUNERAL DIRECTOR <i>Walter Miller - 2331</i>		ADDRESS <i>Lefferson St</i>		25a. REC'D BY REGISTRAR <i>JAN 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

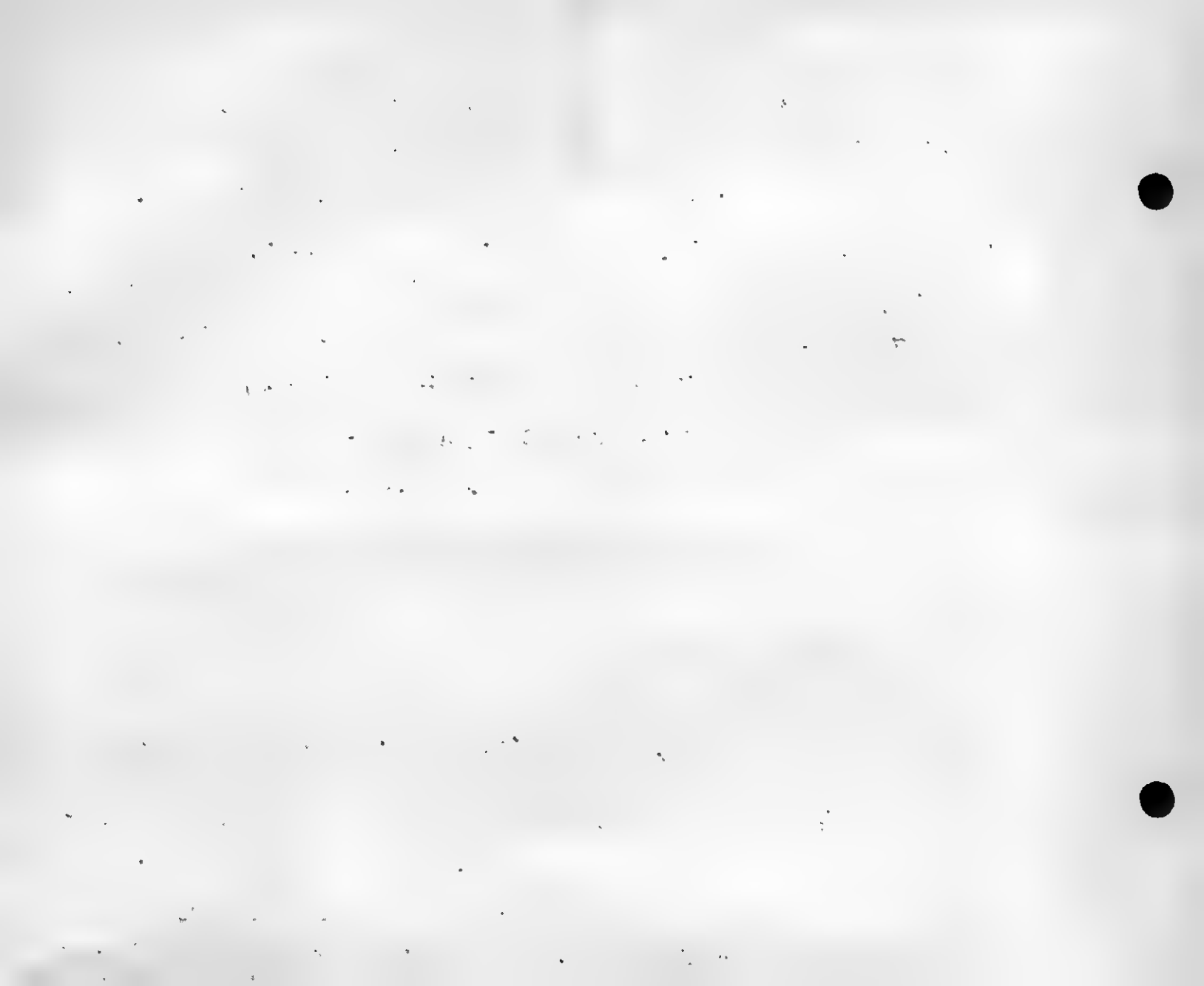


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

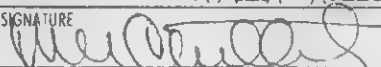

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

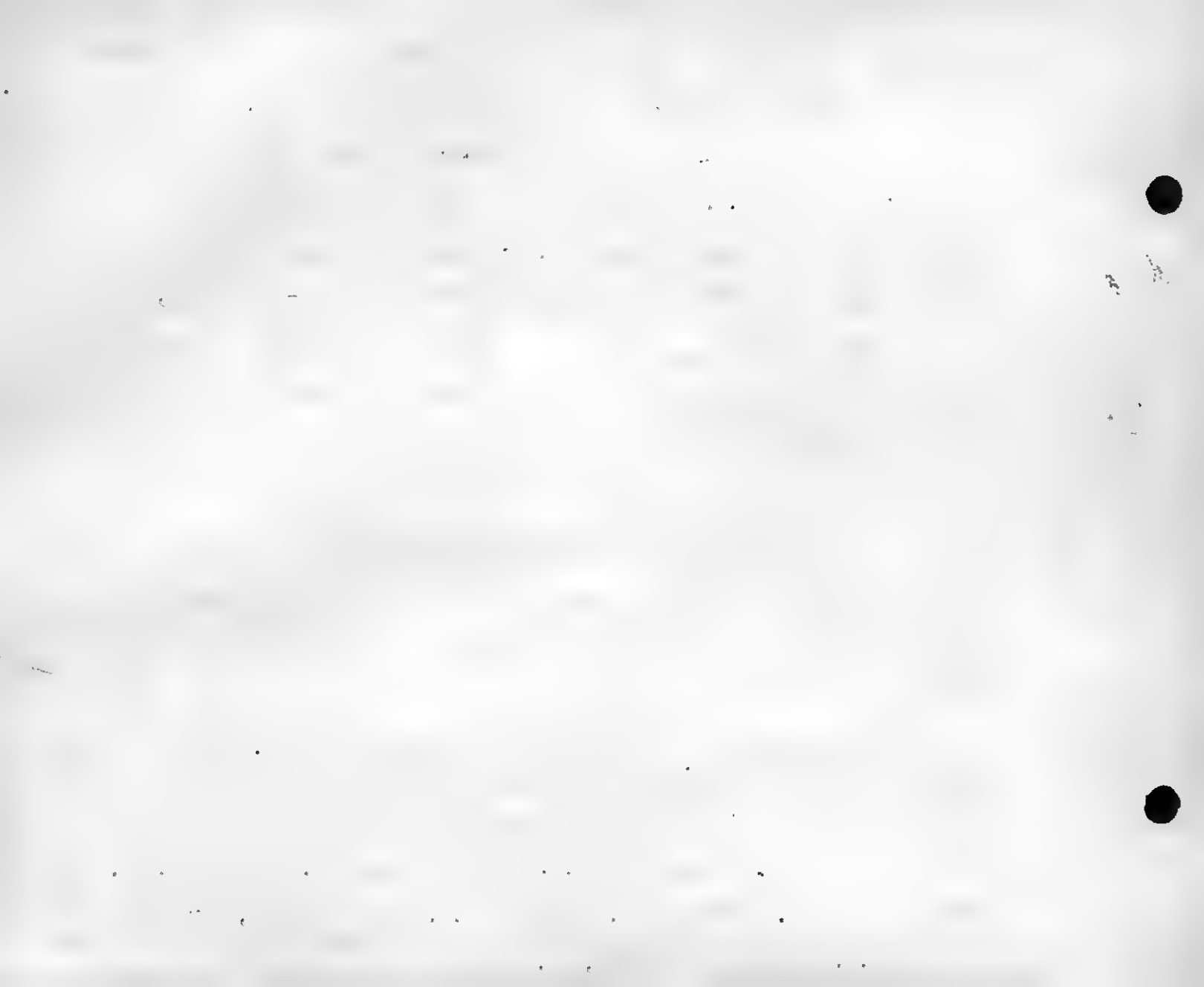
1. DECEASED NAME (Type or print) <b>RAYMOND LEE ELLIOTT</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>69</b>			2b. HOUR M	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5-3-85</b>		6. AGE (In years lost birthday) <b>83</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ANN ARUNDEL</b> Md.	
10. CITY OR TOWN OF DEATH <b>CROWNSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CROWNSVILLE STATE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PAINTER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>307 N GREEN</b>		14. FATHER'S NAME First <b>CHARLES</b> Middle <b>ELLIOTT</b> Last <b>ELLIOTT</b>		15. MOTHER'S MAIDEN NAME First <b>VIRGINIA</b> Middle <b>GIFFIN</b> Last <b>GIFFIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>578-14-4370A</b>		17. INFORMANT <b>HOSPITAL RECORD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>412X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-22</b> , 19 <b>68</b> , to <b>1-10</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-10-69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John J. M. Giffin, M.D.</b> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-10-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Giffin</b>				22e. ADDRESS <b>CROWNSVILLE STATE HOSP</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-15-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Whitacre, Frederick Co, Va</b>	
24. FUNERAL DIRECTOR <b>Giffin Funeral Home, Capon Bridge, W. Va 26711</b>				25a. REC'D BY REGISTRAR <b>JAN 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00148									
CERTIFICATE OF DEATH									
00147									
1 DECEASED-NAME (Type or print) First Middle Last <b>LeRoy Hance EPPS</b>					2a. DATE OF DEATH Month Day Year <b>January 18 1969</b>			2b. HOUR P. <b>2:01 M</b>	
3 SEX <b>Male</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>January 18, 1969</b>		6 AGE (In years last birthday) <b>— YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>0 1</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Anne Arundel Gen. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Newborn</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Severna Park</b>		13d. INS. DE CITY, M.T.S? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>Rt-1, Box 331,</b>	
14 FATHER'S NAME First Middle Last <b>Donald LeRoy Epps</b>					15 MOTHER'S M.A.DEN NAME First Middle Last <b>Linda Rose Hance Gabriel</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>None</b>		17 INFORMANT Address <b>Hospital Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Placental insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>Jan. 18 1969</b> to <b>Jan. 18, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan. 18, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE  M.D.				22c. DATE SIGNED <b>1/21/69</b>		22d. PHYSICIAN'S NAME (Type) <b>Nelson M. Chitterling, M.D.</b>			
22e. ADDRESS <b>95 Cathedral St., Annapolis, Md.</b>									
23a. BURIAL CREMATION, (Specify) <b>Burial</b>		23b. DATE <b>Jan. 27-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balt. National U.S.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24 FUNERAL DIRECTOR <b>C.E. Hicks 111 Annapolis, Md.</b>				25a. RECORD RECORDED <b>JAN 28 1969</b>		25b. REGISTRAR'S SIGNATURE 			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00149

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00148

1 DECEASED NAME (Type or Print)		(or First Middle Last EDWARD D. FERRARI		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 1 13 19 69		2b HOUR 1:45	
3 SEX Male	4 RACE White	5 DATE OF BIRTH June 21, 1924	6 AGE (In years last birthday) 44 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year January 13 19 69	
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel Md.	
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Electrician		12b KIND OF BUSINESS OR INDUSTRY Ft. Meade	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Balto.		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Drive 21225 595 Terrace Ave.	
14 FATHER'S NAME First Middle Last Edward Ferrari		15 MOTHER'S MAIDEN NAME First Middle Last Helen Stevens		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WW 2			
16b SOCIAL SECURITY NO 216-16-8718		17 INFORMANT ADDRESS Donna Lee Ferrari, dght. 6217 Birchwood Ave.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries</u> 15.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> (CAUSE OF DEATH)		21b TIME OF INJURY Month, Day, Year HOUR A.M. 12:30 PM 1 13 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver in auto-fixed object coll.			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No City or Town County State Hammonds Lane Annapolis A. A. Md.			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MED. CAL. EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED 1/13/69			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE 1/17/69		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a REC'D BY REGISTRAR DATE JAN 20 1969		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 110-4  
30M REV 1-58

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
00150												
JUL 19 1969												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>Resario (Robert) Fertitta</b>						2a. DATE OF DEATH Month Day Year <b>January 12, 1969</b>			2b. HOUR <b>8 A.M.</b>			
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 20, 1892</b>			6. AGE (In years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Italy</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel, Md.</b>						
10. CITY OR TOWN OF DEATH <b>Arnold</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Shore Acres Drive</b>				12a. USUAL OCCUPATION (Kind of work done) <b>Self-employed in Trucking</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>				13b. CITY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Arnold</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Shore Acres Drive</b>		
14. FATHER'S NAME First Middle Last <b>Vincent Fertitta</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Rosaria Micciche</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown <b>no</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>216-32-6438</b>		17. INFORMANT Address <b>Louis Sabatino 925 B reezewick Circle</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF (R) LUNG</b>												
(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION <b>8/27/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Lung</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 27, 1968</b> , to <b>Jan 4, 1969</b> , that (I) (we) lost the deceased on <b>Jan 4, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>George G. Finney, Jr.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/13/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>George G. Finney, Jr.</b>						22e. ADDRESS <b>5820 York Road</b>						
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Buried</b>		23b. DATE <b>1/15/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>				
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>						ADDRESS		25a. RECEIVED BY REGISTRAR <b>JAN 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

00151		DIVISION OF VITAL RECORDS, 700 WESTON STREET, BALTIMORE, MARYLAND 21201		J0150	
1 DECEASED-NAME (Type or print) <b>Sylvia Dale FETHERSTON</b>			2a DATE OF DEATH <b>January 4, 1969</b>		2b. HOUR P <b>10:54M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>May 18, 1924</b>	6 AGE (In years last birthday) <b>44</b> YRS	11 UNDER 1 YEAR MONTHS	12 UNDER 24 HRS HOURS
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH <b>Anne Arundel County Md</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Anne Arundel General Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a USJA. RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Anne Arundel</b>	13c CITY OR TOWN <b>Annapolis</b>	13d NS DE CITY, MITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>105 Claude Street</b>	
14 FATHER'S NAME First <b>Not Known</b> Middle <b>Not Known</b> Last <b>Not Known</b>	15 MOTHER'S MAIDEN NAME First <b>Not Known</b> Middle <b>Not Known</b> Last <b>Not Known</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT <b>Mrs Sylvia Jewell</b> Address <b>13e</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>471X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cholesterol</b> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebrovascular accident.</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 4, 1969</b> to <b>Jan 4, 1969</b> , that (I) (we) lost saw the deceased alive on <b>Jan 4, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>John L. Hedeman</b>	DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>1/5/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>John L. Hedeman, M. D.</b>	22e ADDRESS <b>1407 Forest Drive, Annapolis, Maryland</b>				
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE <b>1-7-69</b>	23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>	23d LOCATION (City or Town) <b>Annapolis</b> (County) <b>Md.</b> (State)		
24a FUNERAL DIRECTOR <b>John M. Laylor &amp; Sons</b>	ADDRESS <b>Annapolis, Md.</b>	25a REC'D BY REGISTRAR <b>JAN 9 1969</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MARYLAND  
1001

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (6)  
10M REV 1/88

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

It. m#2a. FilmGL09 2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Jan. 28 1969		2b. HOUR	
CHARLES		FISHER									
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR		
Male	Negro	2/9/29	39 YRS					January 27, 69	8:30		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.				
Virginia, U.S.A.			U.S.A.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			(DOA) Anne Arundel Gen. Hospital			Bar Tender			U.S. Officer		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Anne Arundel			Annapolis		YES <input type="checkbox"/> NO <input type="checkbox"/>		39 Pinkney Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
James Fisher			Mary Fisher								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						Rachel Fisher - Anna, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
		19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
Charles S. Springate				M.D.				January 27, 1969			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)			
Charles S. Springate, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		1/30/69		Green Lawn Mem. Pk.		Annapolis		D.C.		Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
William Reese, Jr. - Anna, Md.				JAN 28 1969				Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M RE 1-708

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #6, Film GL09 1/30/69 km									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
John			Fleetwood			1/ 21/ 69			6:15p
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		5/7/84		85 81 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		US				Anne Arundel Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Crownsville			Crownsville State Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Anne Arundel					Rt 5, St. Margarets	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Charles Fleetwood			Elsie Fleetwood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			unknown		Hospital Records, Crownsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Lt U.L.</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>ASCVD, decompensated</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cachexia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CA of the sigmoid, resected. Transurethral prostatectomy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>65</u> , to <u>1/22/</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/22/</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Nick P. Moutsos</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/22/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Nick P. Moutsos, M.D.</u>					22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>1-25-1969</u>		<u>St. Margaret</u>		<u>St. Margarets</u>			
24. FUNERAL DIRECTOR <u>William Beese # 10000</u>					25a. REC'D BY REGISTRAR <u>JAN 24 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print) <b>Earlie C Forrester</b>					2a. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1969</b>			2b. HOUR <b>10:55M</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>August 1, 1896</b>		6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____ IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.			
10. CITY OR TOWN OF DEATH <b>Millersville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Knollwood Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Chesapeake</b>		13c. CITY OR TOWN <b>Chesapeake</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>David H. Forrester</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Castana Hill</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16b. SOC. SEC. NO. <b>57901-1767</b>		17. INFORMANT <b>Frances Forrester Churchton</b> Address _____					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized carcinomatosis, carcinoma of colon</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION <b>1965</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of colon</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NA</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that ( ) (the hospital) attended the deceased from <b>January 9, 1969</b> , to <b>January 16, 1969</b> , that (I) (we) last saw the deceased alive on <b>January 15, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles W. Kinzer</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>January 17, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>				22e. ADDRESS <b>16 Murravy Ave., Annapolis, Md. 21401</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-21-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Balto.</b>		23d. LOCATION (City or Town) (County) (State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>William Reesett</b>				ADDRESS <b>Chesapeake</b>		25a. REC'D BY REG. STRAR DATE <b>JAN 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)  
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Emma J. FREEMAN						JAN Month 21 Day 1969			- M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
FEMALE		WHITE		JAN 5, 1880		89 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
ANNAPOLIS MD		USA				ANNE ARUNDEL Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
St. Margaret's		BAYMANOR NUR. HOME		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE CITY - WHITE? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		AA. Co.		ANNAPOLIS				1 BLOOMS BURY SQ	
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Z E K E					MITCHELL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or (if known))			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
NO						JOSEPH FREEMAN #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE								15 YEARS	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) DUE TO, OR AS A CONSEQUENCE OF	
								(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from June 19, 1935 to 19, 1969, that (1) (we) last saw the deceased alive on 17 JAN 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
Edward S. Beck									1-24-69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Edward S. Beck, M.D.					73 Franklin St., Annapolis, Md.				
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JAN 24, 1969		ANNAP. NATIONAL CEM.		ANNAPOLIS MD			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
JOHN M. TAYLOR & SONS					ANNAPOLIS MD		JAN 27 1969		Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00150

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00155

## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last George Robert Fulda			2a. DATE OF DEATH Month 25 Day 1969 Year			2b. HOUR 1:20 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 1-13-00		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. CITY Anne Arundel		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt. 2 Box 220 Oakdale Circle	
14. FATHER'S NAME First Middle Last ?			15. MOTHER'S MAIDEN NAME First Middle Last ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO —		17. INFORMANT Margaret Scott		Address Abner	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Emboli? 41 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASD DUE TO, OR AS A CONSEQUENCE OF (c) Myocardium							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Myocardium							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/19/69 to 1/25/69, that (I) (we) last saw the deceased alive on 1/24/69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. B. RAM		22c. DATE SIGNED 1/25/69		22d. PHYSICIAN'S NAME (Type) J. B. RAM MD 2		22e. ADDRESS 325 Hospital Dr. Glen Burnie Md 21061	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-28-69		23c. NAME OF CEMETERY OR CREMATORY Lanham Park		23d. LOCATION (City or Town) (County) (State) Woodlawn Bethesda Md	
24. FUNERAL DIRECTOR Robert S. Baranov		25a. RECD BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

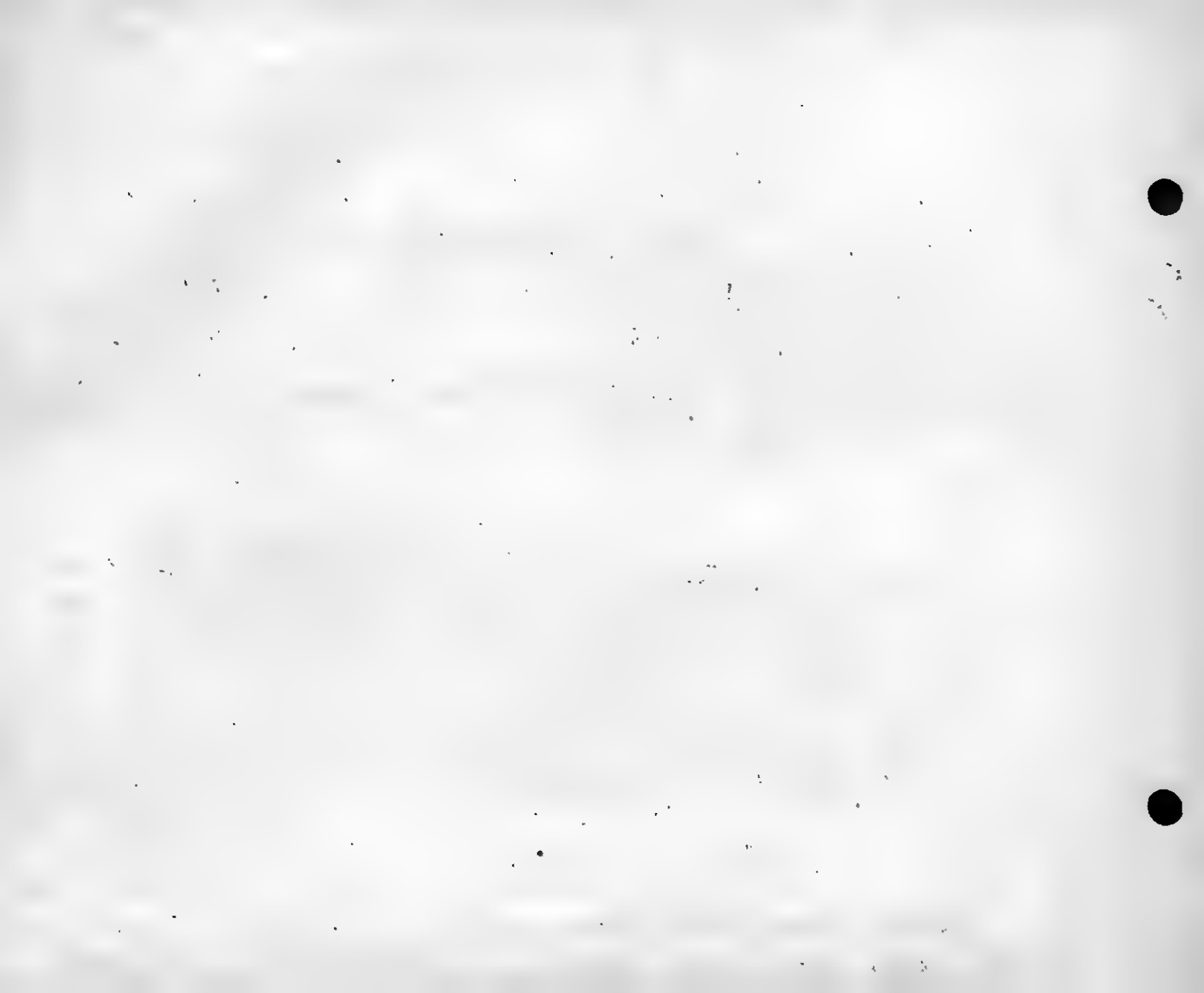
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR
Freeman				Gault				Month 1	Day 5	Year 69
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		Negro		10/14/24		44 YRS		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		COUNTY OF DEATH				
South Carolina		USA				Anne Arundel				MD
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Crownsville		Crownsville State Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Balto		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		1706 Darley Avenue		
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First
Daniel		Gault						Bessie		West
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address				
no		215-14-8538		Hospital Records, Crownsville State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia -</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>mal nutrition</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic alcoholism -</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County
While <input type="checkbox"/> Not while <input type="checkbox"/>										
at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>68</u> , to <u>1-5</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
<u>Alberto Gonzalez</u>		12/5/69		Alberto Gonzalez, M.D.		Crownsville State Hospital, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
<u>Burial</u>		1-9-69		<u>Mt. Calvary</u>		<u>A.A. County, Md.</u>				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
<u>Joseph E. Locks</u>		JAN 7 1969		<u>[Signature]</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <b>George Leroy Gibson</b>						2a. DATE OF DEATH <b>January 14 1969</b>			2b. HOUR <b>6:10 AM</b>		
3 SEX <b>Male</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>October 24 1911</b>		6. AGE (In years last birthday) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CIT. ZEN. OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Anne Arundel</b> Md.					
10. CITY OR TOWN OF DEATH <b>Croftsville</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Croftsville State Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>33 South Bond St</b>	
14. FATHER'S NAME <b>Saloma A. Gibson</b>				15. MOTHER'S MAIDEN NAME <b>Virginia Jackson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. <b>579-16-9283</b>		17 INFIRMITY <b>Medical Records - Croftsville State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Pneumonia</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Old Myocardial Infarction; Old CVA; Nephritis; Epilepsy</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY <b>19</b> HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> , 19 <b>64</b> , to <b>1/11</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert McHenry Mapp</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/14/69</b>					
22d. PHYSICIAN'S NAME (Type) <b>Robert McHenry Mapp</b>		22e. ADDRESS <b>Croftsville State Hospital</b>		22f. ADDRESS <b>Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JAN. 14, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER</b>		23d. LOCATION (City or Town) <b>Middleburg</b>		County <b>Fauquier</b>		State <b>VA.</b>	
24. FUNERAL DIRECTOR <b>James M. Moser</b>		ADDRESS <b>Fun. Home</b>		25a. REC'D BY REGISTRAR <b>JAN 15 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

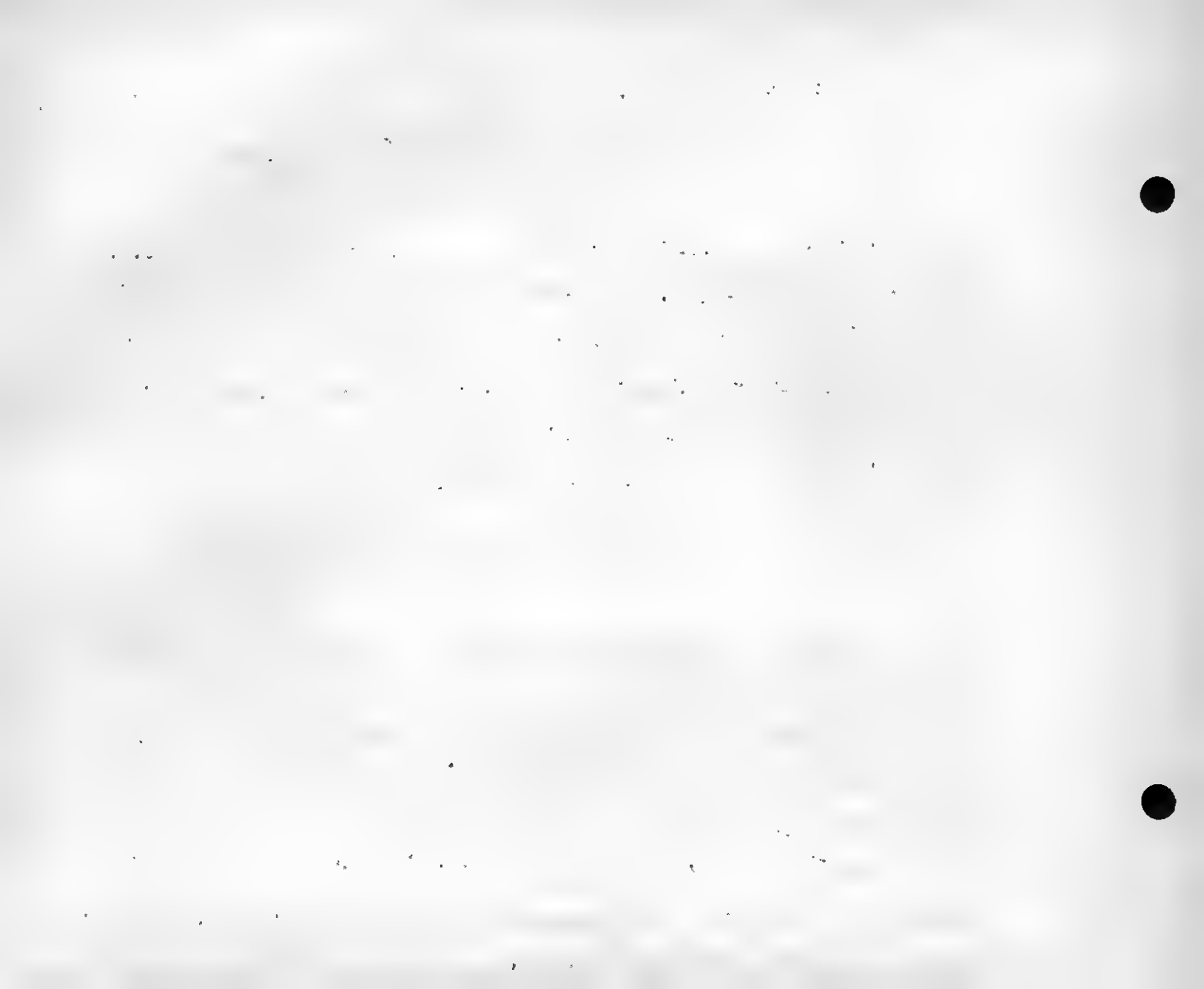
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

00150

00158

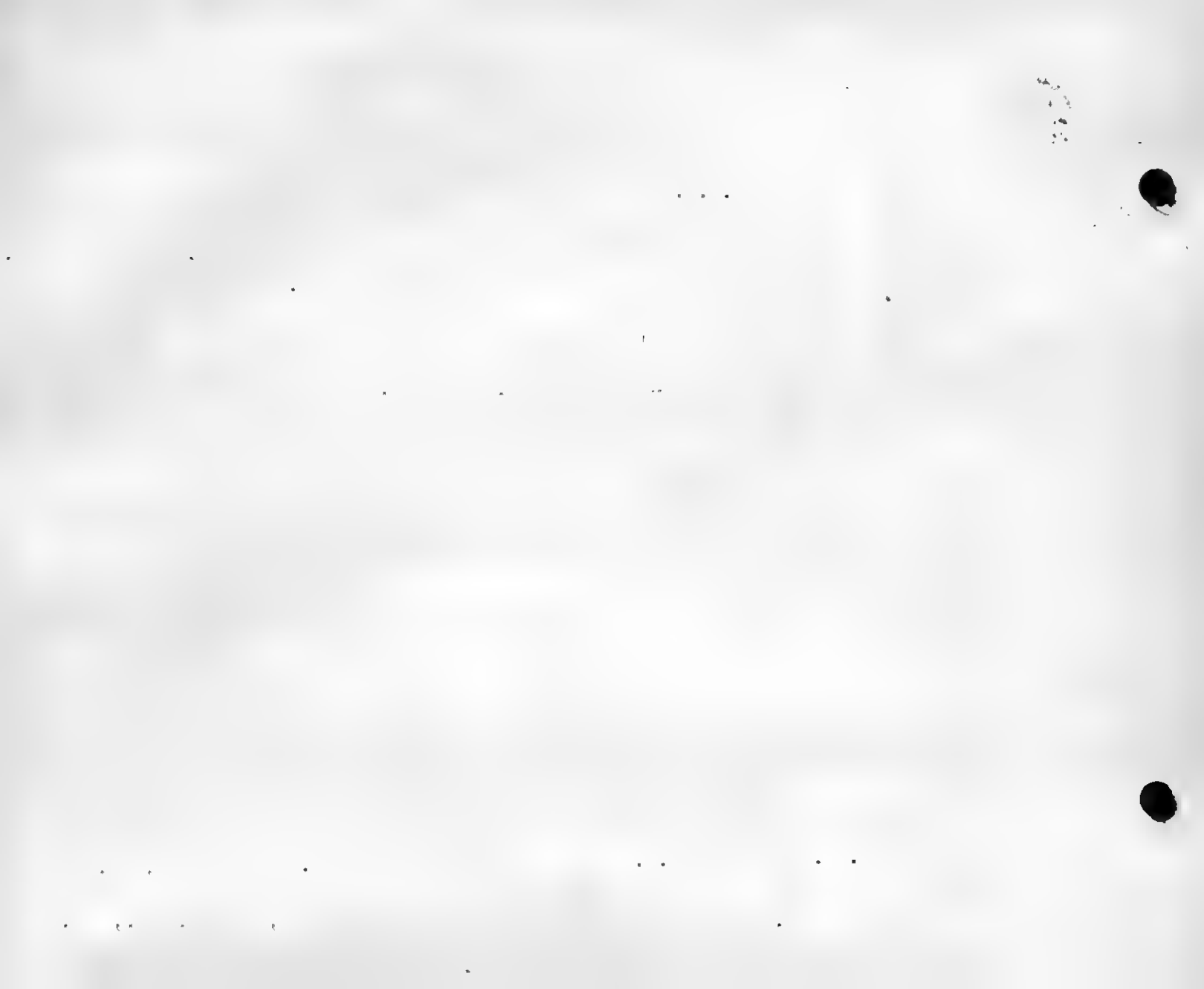
1 DECEASED NAME (Type or print) <b>THOMAS</b>		First <b>THOMAS</b> Middle <b>H.</b> Last <b>GOODE</b>		2a. DATE OF DEATH <b>JAN</b> Month <b>12</b> Day <b>1969</b> Year		2b. HOUR <b>2:15</b> M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>17 Dec 1926</b>		6. AGE (In years last birthday) <b>42</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.	
10 CITY OR TOWN OF DEATH <b>Ft Geo G. Meade</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>U.S. Kimbrough Army Hosp</b>		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <b>Retired Officer</b>		12b KIND OF BUSINESS OR INDUSTRY <b>U.S.ARMY</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <b>Maryland</b>		13b COUNTY <b>Anne Arundel</b>		13c CITY OR TOWN <b>Odenton</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <b>526 Maple Ridge Lane</b>		14 FATHER'S NAME First <b>John</b> Middle <b>H.</b> Last <b>Goode, Sr.</b>		15. MOTHER'S MAIDEN NAME First <b>Lollie</b> Middle <b>Seldon</b> Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b SOCIAL SECURITY NO <b>1945-1965</b>		17. INFORMANT (wife) <b>Mrs. Rita Goode, 526 Maple Ridge Lane</b>		Address <b>Odenton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> <b>571.8</b> DUE TO, OR AS A CONSEQUENCE OF POST NECROTIC CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 Yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>10 Dec</b> , 19 <b>68</b> , to <b>12 Jan</b> , 19 <b>69</b> , that <del>he</del> (we) last saw the deceased alive on <b>12 Jan</b> , 19 <b>69</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Herbert Spolter</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED <b>12 January 1969</b>	
22d PHYSICIAN'S NAME (Type) <b>HERBERT SPOLTER, CPT, MC</b>				22e ADDRESS <b>U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/15/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Raymond C. Fink</b>				ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 16 1969</b> DATE	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00159					
CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or print) Marie			First Middle Last		2a. DATE OF DEATH Jan. Month 28 Day 69 Year			2b. HOUR 6:45 PM							
3 SEX Female		4 RACE White		5 DATE OF BIRTH 8-30-94		6 AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel			Md.						
10 CITY OR TOWN OF DEATH Glen Burnie		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) North Arundel Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress (ret.)		12b KIND OF BUSINESS OR INDUSTRY Garment Ind.									
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Anne Arundel		13c CITY OR TOWN Crownsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rt. 2 Box 416							
4 FATHER'S NAME Patrick			First Middle Last O'Connell		15 MOTHER'S MAIDEN NAME Mary Grimes										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		(If yes give war or dates of service) None		16b. SOCIAL SECURITY NO 213-05-0263		17. INFORMANT Mr. Lewis A. Grimes (son) Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bilateral										24					
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic CARCINOMA Breast Gen															
DUE TO, OR AS A CONSEQUENCE OF (c) Post Operative Incarcerated Hernia 7 days.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION 1-22-69										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hernia, Inguinal, strang. (R)		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1-28-69, 19 to 1-28, 1969, that (I) (we) last saw the deceased alive on 1-28-69, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.															
22b. SIGNATURE C. R. MacDonald M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-28-69							
22d. PHYSICIAN'S NAME (Type) C. R. MacDonald M.D.				22e. ADDRESS 325 Hospital Dr. Glen Burnie, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 1, 1969		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Boring, Balto. Co., Md.									
24. FUNERAL DIRECTOR Singleton Funeral Home				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR JAN 31 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last George Austin GUTHRIE						2a. DATE OF DEATH Month Day Year January 9, 1969			2b. HOUR A 7:15 M		
3 SEX M		4. RACE W		5. DATE OF BIRTH 3-9-1916		6. AGE (in years last birthday) 52 YRS.		F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A. GENERAL			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) CIVIL SERVICE			12b. KIND OF BUSINESS OR INDUSTRY RET.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY A.A.			13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 113 GREAT OAK DR.	
14. FATHER'S NAME First Middle Last Frank L. GUTHRIE			15. MOTHER'S MAIDEN NAME First Middle Last Mary V. ADAMS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES WW II			16b. SOCIAL SECURITY NO.			17. INFORMANT Catherine G. Guthrie #13			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hypertensive - arteriosclerotic cardiovascular disease</u> 4121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (c) <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/8, 1968, to 12/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Richard I. Hochman, M.D.						DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 1/9/69	
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M. D.						22e. ADDRESS 16 Murray Avenue, Annapolis, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-11-69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest				23d. LOCATION (City or Town) (County) (State) Annapolis A.A. MD.			
24. FUNERAL DIRECTOR John M. Loxton		25a. REG. BY REG. STR. DATE JAN 14 1969									
25b. REGISTRAR'S SIGNATURE James Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
ROBERT			L HALL			1 Month 30 Day Year		698.20 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		Negro		April 1915		53 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		US				A.A. County, Glen Burnie Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done last of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			North Arundel Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			A.A.		Glen Burnie				Quarterfield & Queens Town Rd	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			1-4-4-4		Chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Cute coronary thrombosis</u>								Sudden		
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>virus pneumonia</u>								Abt 20 days		
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Obesity</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1969, to Jan 30, 1969, that (I) (we) last saw the deceased alive on Jan 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED							
Paul J. Chang M.D.			1/30/69							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Dr. Paul Chang			801 Green Hwy 53, Glen Burnie, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			1-3-69		Baltimore Nat. C.		Baltimore Md			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
E.O. Williams 1000 Kentucky Ave.						DATE FEB 6 1969		J. Williams Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

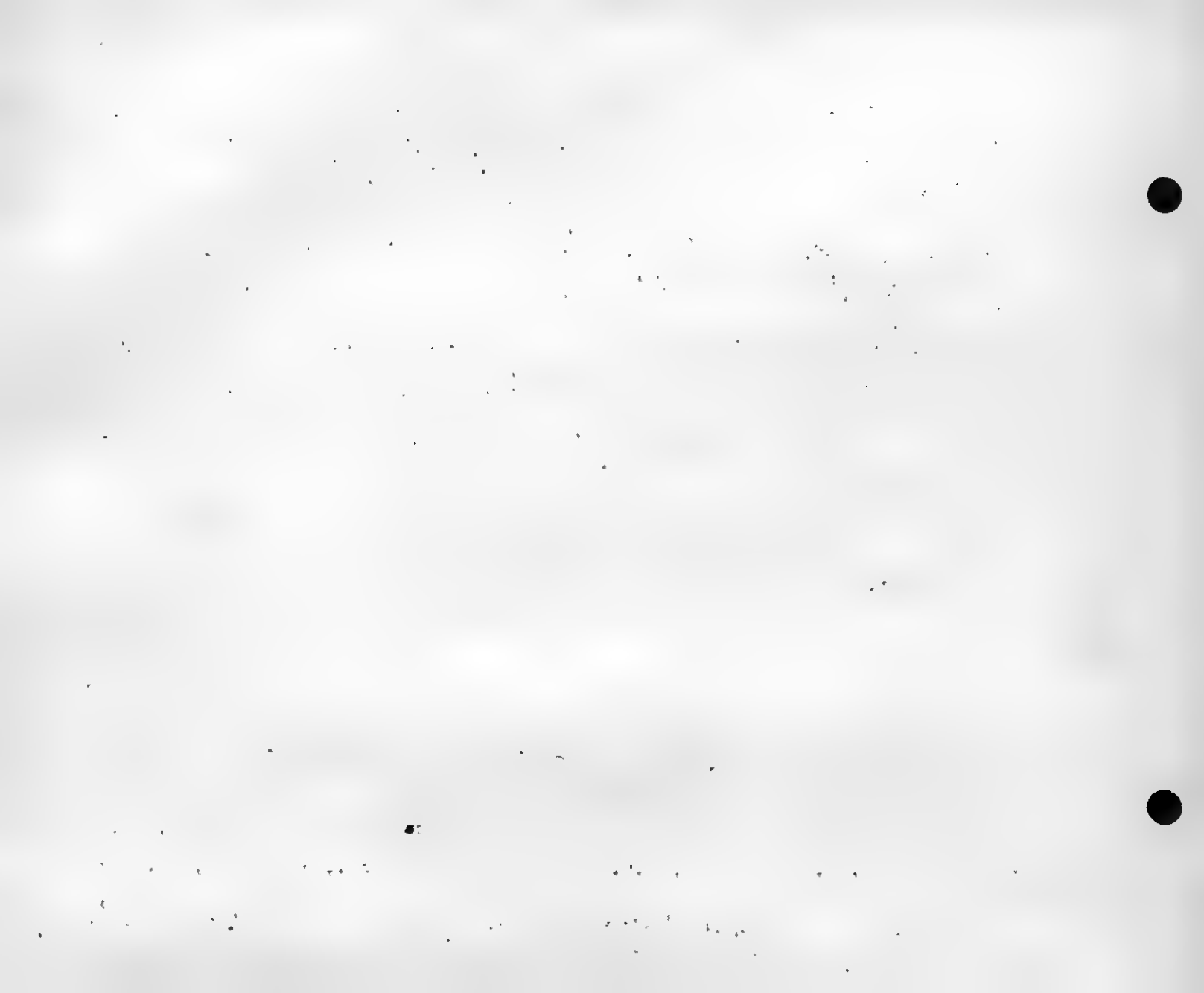
00163		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00162					
Item 6 Film 408 1/23/69 kk						CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First ANNIE		Middle MAY	Last HAMILTON		2a. DATE OF DEATH Month Day Year Jan 19 1969		2b. HOUR 11:45 PM		
3 SEX Female		4. RACE White		5. DATE OF BIRTH October 4, 1896		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Anne Arundel		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Genl Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Operator		12b. KIND OF BUSINESS OR INDUSTRY Box Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Poplar Ridge 1898 Cedar Rd. Pasadena Md.			
14. FATHER'S NAME First Middle Last Charles T. Eslein		15. MOTHER'S MAIDEN NAME First Middle Last Mary E. Callender									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mary Dillard 405 Stately Dr. Pasadena					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours hours years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized Arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 20 1968</u> , to <u>Jan 19 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Max C. Frank</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 1/20/69					
22d. PHYSICIAN'S NAME (Type) MAX C. FRANK		22e. ADDRESS 425 SE Ritchie Hwy - Glen Burnie									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/23/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Ritchie Highway A. A. Co. Md					
24. FUNERAL DIRECTOR <u>McCully F. A.</u>		ADDRESS 237 Patapsco Ave. 21275		25a. REC'D BY REGISTRAR JAN 21 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 526 correct File # 009 2/10/69 kk 00164		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00163	
1 DECEASED NAME (Type or print) <b>Rosie I Hamilton</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>27</b> Year <b>69</b>		2b HOUR <b>5:15a M</b>
3 SEX <b>Female</b>	4 RACE <b>Colored American</b>	5 DATE OF BIRTH <b>5/10/1899</b>		6 AGE (In years last birthday) <b>69</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) <b>Md.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Anne Arundel</b> Md.		
10 CITY OR TOWN OF DEATH <b>Annapolis</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3000 Terrace</b>	12a USUA. OCCUPATION (Kind of work done during most of working life, even if not paid)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Md.</b>	13b COUNTY <b>U. C. Anna.</b>	13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>3000 Terrace</b>		
14 FATHER'S NAME First <b>William</b> Middle <b>Stright</b> Last <b>Stright</b>	15 MOTHER'S MAIDEN NAME First <b>Charlotte</b> Middle <b>Harrod</b> Last <b>Harrod</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>	16b SOCIAL SECURITY NO. <b>216-36-2941D</b>	17 INFORMANT Address <b>Charlotte Hayden - Anna, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Esophagus</b> <b>150 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>None</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 27</b> , 19 <b>68</b> , to <b>Jan. 27</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Jan. 27</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. L. Richardson</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <b>Jan. 28, 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>R. L. Richardson, M.D.</b>		22e ADDRESS <b>110 Clay St., Annapolis, Md., 21401</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE <b>1/30/69</b>	23c NAME OF CEMETERY OR CREMATORY <b>Annapolis Natl.</b>	23d LOCATION (City or Town) <b>Annapolis</b>	(County) <b>U. C. Md.</b>	(State)
24 FUNERAL DIRECTOR <b>William Reese, Jr - Anna, Md.</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b>		25b REGISTRAR'S SIGNATURE	
DATE <b>JAN 29 1969</b>					

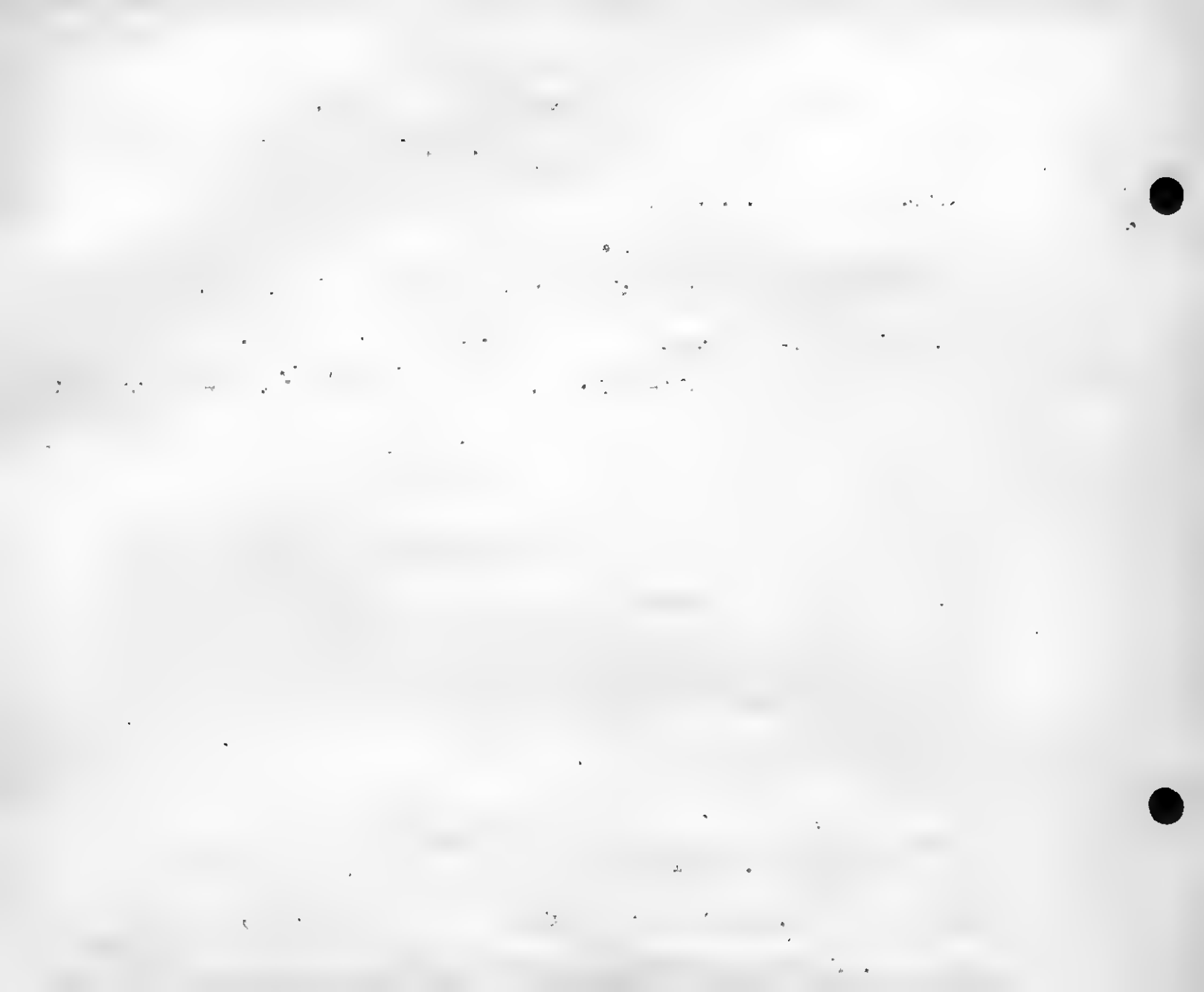


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>JOE</b> <b>MMN</b> <b>HENSON</b>			2a. DATE OF DEATH Jan. Month 19 Day 69 Year			2b. HOUR M			
3 SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>Feb. 11, 1897</b>		6. AGE (In years by birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1159 Eastport Terrace</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1159 Eastport Terrace</b>	
14. FATHER'S NAME First Middle Last <b>Benjamin</b> <b>MMN</b> <b>Henson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Louise</b> <b>MMN</b> <b>Boone</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>214-05-0680</b>		17. INFORMANT <b>Annapolis, Md.</b> Address <b>Terrace</b> <b>Margaret or Magurite Henson-1159 Eastport</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>+337</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>21 DAYS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GOVT</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from <b>1 AUG 1966</b> , to <b>19 JAN 1969</b> , that (1) (we) last saw the deceased alive on <b>15 JAN 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Edward S. Beck Md</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-21-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Edward S. Beck Md</b>				22e. ADDRESS <b>73 Franklin Street</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 24-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis, Maryland</b>			
24. FUNERAL DIRECTOR ADDRESS <b>C.E. HICKS 111 Annapolis, Maryland</b>				25a. REC'D BY REGISTRAR <b>JAN 28 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 155-1  
304M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First <b>JOHN</b> Middle <b>P.</b> Last <b>HICKMON</b>			2a. DATE OF DEATH JAN Month 25 Day 1969 Year			2b. HOUR 8:20 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 3, 1947		6. AGE (In years last birthday) 22 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS M N	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Fort Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Serviceman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY, TOWNSHIP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Cockeys Mill Road	
14. FATHER'S NAME First William Middle Hickmon Last			15. MOTHER'S MAIDEN NAME First Martha Middle Merkel Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 1966 - 1969 214-50-3046		17. INFORMANT Address 201 File, Dover Air Force Base, Delaware					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>14.7</u> Laceration of thoracic aorta with hemorrhagic shock DUE TO, OR AS A CONSEQUENCE OF (b) Trauma after struck by automobile DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple fractures both lower legs, ribs, sternum & small subarachnoid hemorrhage									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY 6:35 PM Jan 25 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Hit by auto while hitching					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Rt 695 & 170 (EBL of Rt 695)		21f. LOCATION Street or R.F.D. No City or Town State H.A.					
22a. I certify that I (this hospital) attended the deceased from 25 Jan, 1969, to 25 Jan, 1969, that I (we) lost saw the deceased alive on 25 Jan 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frederick Shuster				22c. DATE SIGNED 25 Jan 1969		22d. PHYSICIAN'S NAME (Type) FREDERICK SHUSTER, CPT, MC			
22e. ADDRESS US KIMBROUGH ARMY HOSP, FT MEADE, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 28, 69		23c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		23d. LOCATION (City or Town) (County) (State) Reisterstown, Md.			
24. FUNERAL DIRECTOR J.F. ELINE & SON, 10 MAIN ST. REISTERSTOWN, MD				25a. REC'D BY REGISTRAR FEB Jan 6 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <b>Margaret</b>					2a. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>69</b>		2b. HOUR <b>9:50p</b>			
3 SEX <b>Female</b>					4. RACE <b>White</b>		5. DATE OF BIRTH <b>10/29/1895</b>		6. AGE (In years last birthday) <b>73 76</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvanian</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b>				
10. CITY OR TOWN OF DEATH <b>Crownsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Crownsville State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>122 Market Street</b>	
14. FATHER'S NAME First Middle Last <b>Emory Sneads</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>none</b>		17 INFORMANT Address <b>Hospital Records, Crownsville State Hosp.</b>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic glomerulonephritis</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b> <b>not mentioned</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>12-20</b> , 19 <b>68</b> , to <b>1-8</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-8</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Albert Gonzales</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-4-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Albert Gonzales</b>					22e. ADDRESS <b>645 Americana Drive Gunabell</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/13/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Gettysburg, Adams Co., Pa.</b>				
24. FUNERAL DIRECTOR <b>Robert M. M...</b>					25a. REC'D BY REGISTRAR DATE <b>JAN 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. M...</b>			

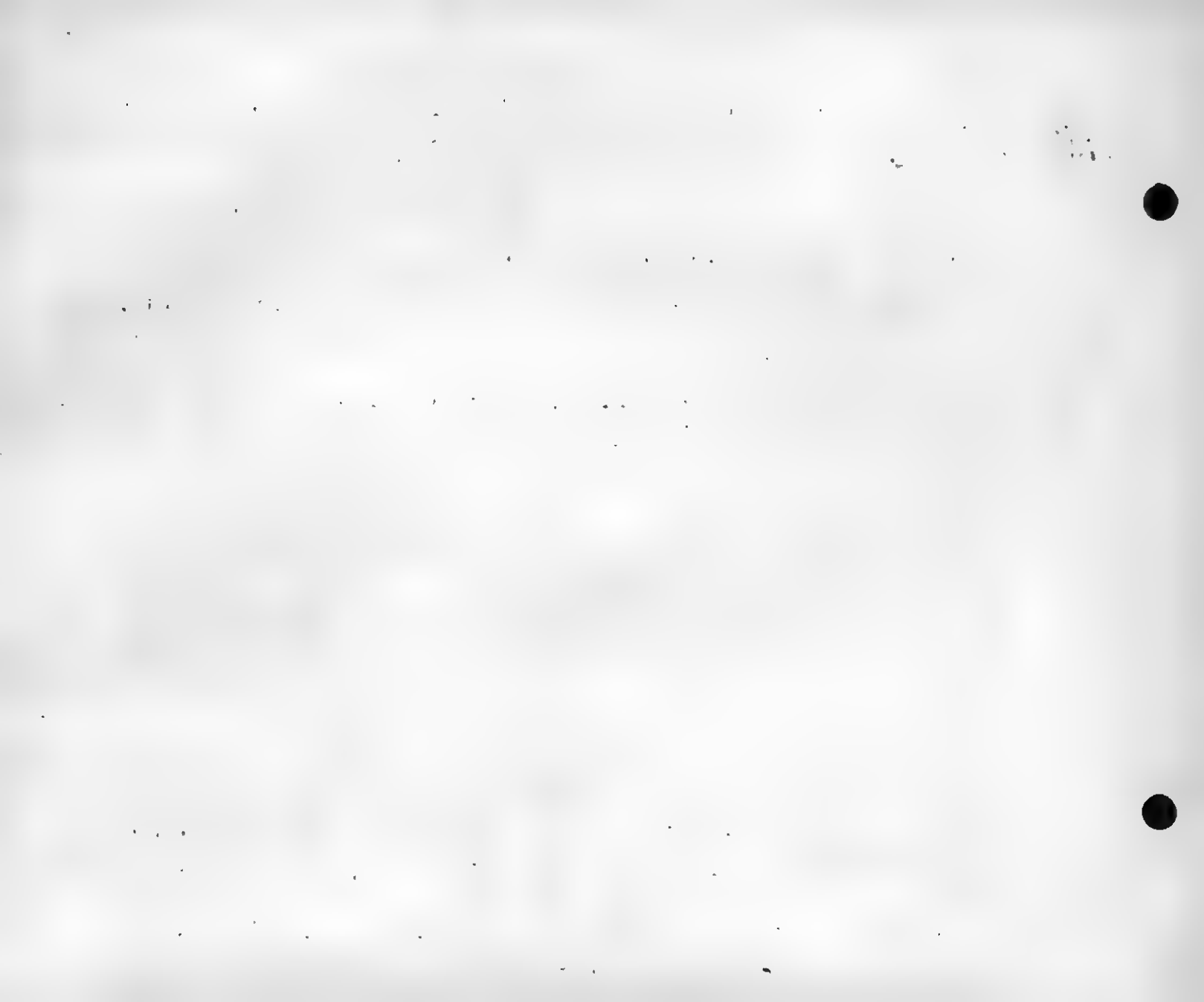


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11)  
30M REV. 7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00160 Item #6, Film GL 79 2/3/69 km										
00167										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
Catherine Holtzer					Month 1 Day 16 Year 69			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
female		White		11/25/01		68 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		US				Anne Arundel Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville			Crownsville State Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		1100 N. Calvert Street	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
unknown					unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no			213-12-2529T		Hospital Records, Crownsville State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism.</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary infection</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>6-5</u> , 19 <u>68</u> , to <u>1-16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Alberto Gonzalez</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/16/69			
22d. PHYSICIAN'S NAME (Type) <u>Alberto Gonzalez</u>					22e. ADDRESS <u>695 Americana Dr. 24 - Annapolis</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<u>burial</u>			<u>1-25-69</u>		<u>Holy Redeemer Cemetery</u>			<u>Fuller, Maryland</u>		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>John C. Miller Inc-6415 B. ...</u>					<u>1-21-69</u>		<u>Charles Judge</u>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00168				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR		
MARIE Z. HOLZINGER									Month Day Year 1 5 69			P M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. UNDER YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR			
F	W	12/18/1991		77 YRS	MONTHS DAYS		HOURS MIN		Month Day Year 1 5 69		P M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Hungary			U.S.A.						Anne Arundel Co Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie				NORTH ARUNDEL				Retired Grocery						
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland				Anne Arundel		Ferndale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		110 Wells Avenue				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First	Middle	Last
Anton			Zietvogel						Elizabeth			Prinz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			21061		
				220-30-4959		Mrs. Anna H. Sisolak			112 Wells Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart disease											Sudden			
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED							
EXAMINER'S NAME (Type)		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>					1-6-69							
E. Linhart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					AACS.							
ADDRESS (Street, city, town, or county)														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)	(State)	Md.		
BURIAL			1-9-1969		Glen Haven Cemetery			Glen Burnie		Anne Arundel		County		
24. FUNERAL DIRECTOR					ADDRESS			25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Howard H. Hubbard, 4107 Wilkens Ave.					21229			JAN 8 1969						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VERIFIED  
DATE 1/17/69

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
001100									
CERTIFICATE OF DEATH									
00169									
1. DECEASED-NAME (Type or print) <i>Robert</i>		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 1:45 M		
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>20 May 1924</i>		6. AGE (In years last birthday) <i>42</i> YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A.A.</i>		Md.	
10. CITY OR TOWN OF DEATH <i>Glenn Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>7878-Amerikwa Circle</i>		12a. USUAL OCCUPATION (Kind at work done during most of working life, even if retired) <i>Inspector</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>M.D.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Amerikwa</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Amerikwa apt 1</i>	
14. FATHER'S NAME <i>Robert</i>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>Emily</i>		First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>yes</i>		16b. SOCIAL SECURITY NO <i>230-12-7634</i>		17. INFORMANT <i>Mrs. Helen E. Howell (wife)</i>		Address <i>Cardner</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized Carcinoma of the</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca Pancreas</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , 19____, to <i>1969</i> , 19____, that (I) (we) last saw the deceased alive on <i>12-30-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>did</i> (did not) view the body after death.									
22b. SIGNATURE <i>Robert R. Hahn</i>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>1-1-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Robert R. HAHN</i>					22e. ADDRESS <i>P.O. Box 73 Severna Park</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6 Jan. 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenn Burnie Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Glenn Burnie Md.</i>			
24. FUNERAL DIRECTOR <i>RV Singleton - Glenn Burnie, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>JAN 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

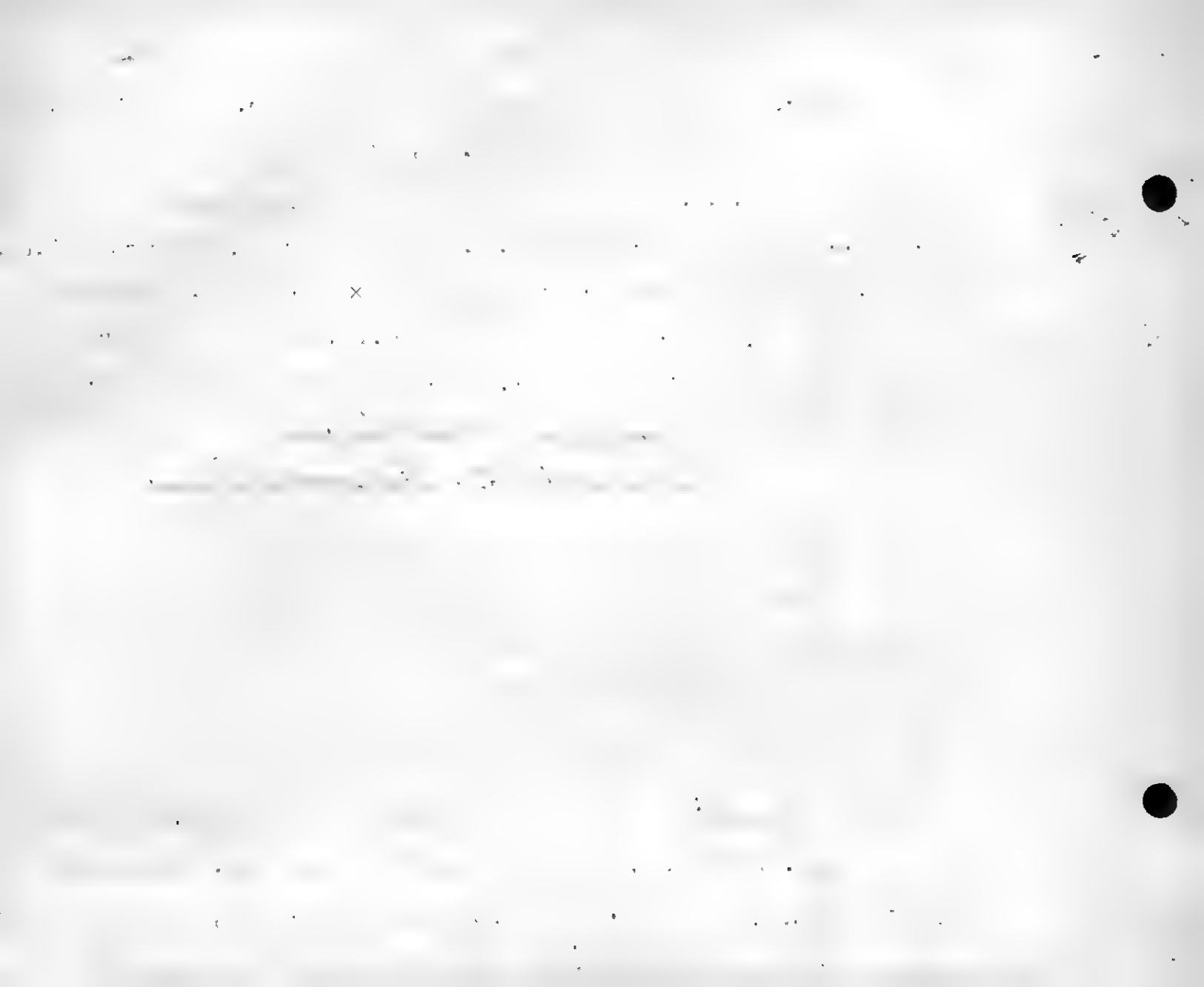
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
20171 CERTIFICATE OF DEATH 00170									
1. DECEASED-NAME (Type or print) First Middle Last <b>JOSEPH C. HOWES</b>					2a. DATE OF DEATH Month Day Year <b>1 14 69</b>		2b. HOUR <b>P</b>		
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>8-9-1899</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ANNE ARUNDEL</b>			
10. CITY OR TOWN OF DEATH <b>ARNOLO</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RT#2 Box 149</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, ever retired) <b>UMBER YARD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>H.A.</b>		13c. CITY OR TOWN <b>ARNOLO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT#2 Box 149</b>	
14. FATHER'S NAME First Middle Last <b>JOHN DUVALL HOWES</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>FLORENCE WARD</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO <b>314 050895</b>		17. INFORMANT <b>Dorothy D. HOWES</b>		Address <b>#13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1968</b> , to <b>Jan. 13, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan. 13, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Theodore G. De Gaevedo</b>				DEGREE <b>MD.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-14-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Theodore G. De Gaevedo</b>				22e. ADDRESS <b>Kitchie Hwy - Arnold - Md.</b>					
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-17-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST</b>		23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS A.H. MD.</b>			
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons</b>				ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>JAN 17 1969</b>									



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages) 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00172										00171														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH										CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR P.M.									
Edward					Hoy					Jan. 17 1969					7:15									
3 SEX		4. RACE		5. DATE OF BIRTH					6. AGE (In years last birthday)					7. UNDER 1 YEAR MONTHS DAYS					8. UNDER 24 HRS HOURS MIN.					
M		W		Oct. 11, 1877					91 YRS.															
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Anne Arundel Md.									
Maryland					U.S.A.																			
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
Millersville					Knollwood N. H.					Machinist (ret.)					Gross Mech. Lab.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER				
Maryland					Anne Arundel					Glen Burnie					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					Sundown Rd. (Ferndale)				
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																			
John T. Hoy					Harriett Elstrood																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address														
no					213 12 4205					Mr. Joseph Hoy (nephew) Same As #13														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF - (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>Ray M. Smith</u>					22c. DATE SIGNED Jan 18, 1969																			
22d. PHYSICIAN'S NAME (Type) Ray M. Smith M. D.					22e. ADDRESS Hahn Professional Bldg., Severna Park, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE Jan. 21/69					23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery					23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland									
24. FUNERAL DIRECTOR <u>R. L. Singleton</u>					ADDRESS Singleton Funeral Home Glen Burnie, Maryland					25a. RECD BY REGISTRAR JAN 22 1969					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00173

00172

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1327 Howard Rd</u>				d. STREET ADDRESS <u>1327 Howard Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kenneth Leamon Huestis</u>				4. DATE OF DEATH Month Day Year <u>1 / 16 1969</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/21/15</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>- - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE MECHANIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>			
16. FATHER'S NAME <u>Hesse Leamon Huestis</u>				14. MOTHER'S MAIDEN NAME <u>BERTHA BLANKENBEKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-07-1495</u>			
17. INFORMANT <u>Barry Marsden Huestis</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> <u>4109</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Basilar Artery Occlusion</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u> <u>6 yrs.</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>- - 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	
20f. (City or town) (County) (State) <u>- - -</u>				20g. (City or town) (County) (State) <u>- - -</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> 19 <u>50</u> to <u>1/8</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/8</u> 19 <u>69</u> , and that death occurred on <u>1/16</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>R.W. Prichard</u>				22b. DATE SIGNED <u>1/17/69</u>			
22c. PHYSICIAN'S NAME (Type) <u>R.W. PRICHARD</u>				22d. ADDRESS <u>Glen Burnie, Maryland</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Jan. 20, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Sangster</u>				25a. REC'D BY REG. STRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Glen Burnie, Md.</u>				DATE <u>JAN 17 1969</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00173- CERTIFICATE OF DEATH 00173										
1. DECEASED-NAME (Type or print)			First Middle Last Frank E. Hutchinson			2a. DATE OF DEATH Month 1/4 Day 89 Year		2b. HOUR 5:00		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 15, 1918		6. AGE (In years last birthday) 50 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Pasadena			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electric		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY A. A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 7 Box 267	
14. FATHER'S NAME First Middle Last Mason Hutchinson			15. MOTHER'S MAIDEN NAME First Middle Last Mattie Hackett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes # 2			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Norma Hutchinson Rt. 7 Box 267					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>DOA</u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>P. Dorkan</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-4-69			
22d. PHYSICIAN'S NAME (Type) <u>P. Dorkan, M.D.</u>					22e. ADDRESS <u>375 Hospital Drive, S. Burnie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1 8 69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Brooklyn, A.A. Co., Md.				
24. FUNERAL DIRECTOR Mc Cully					ADDRESS 130 E. Fort Ave.		25a. REC'D BY REGISTRAR DATE JAN 9 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

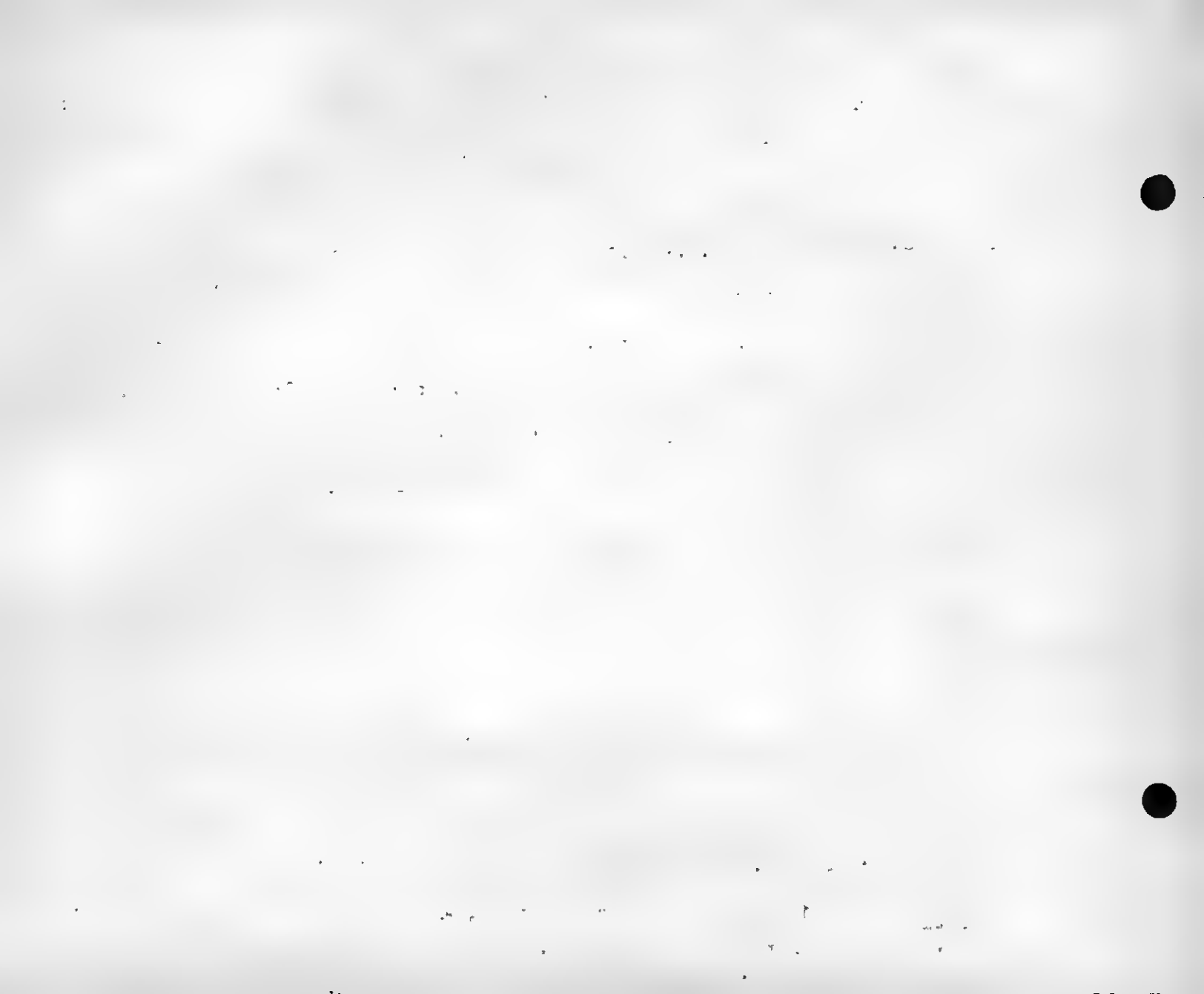


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbar papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

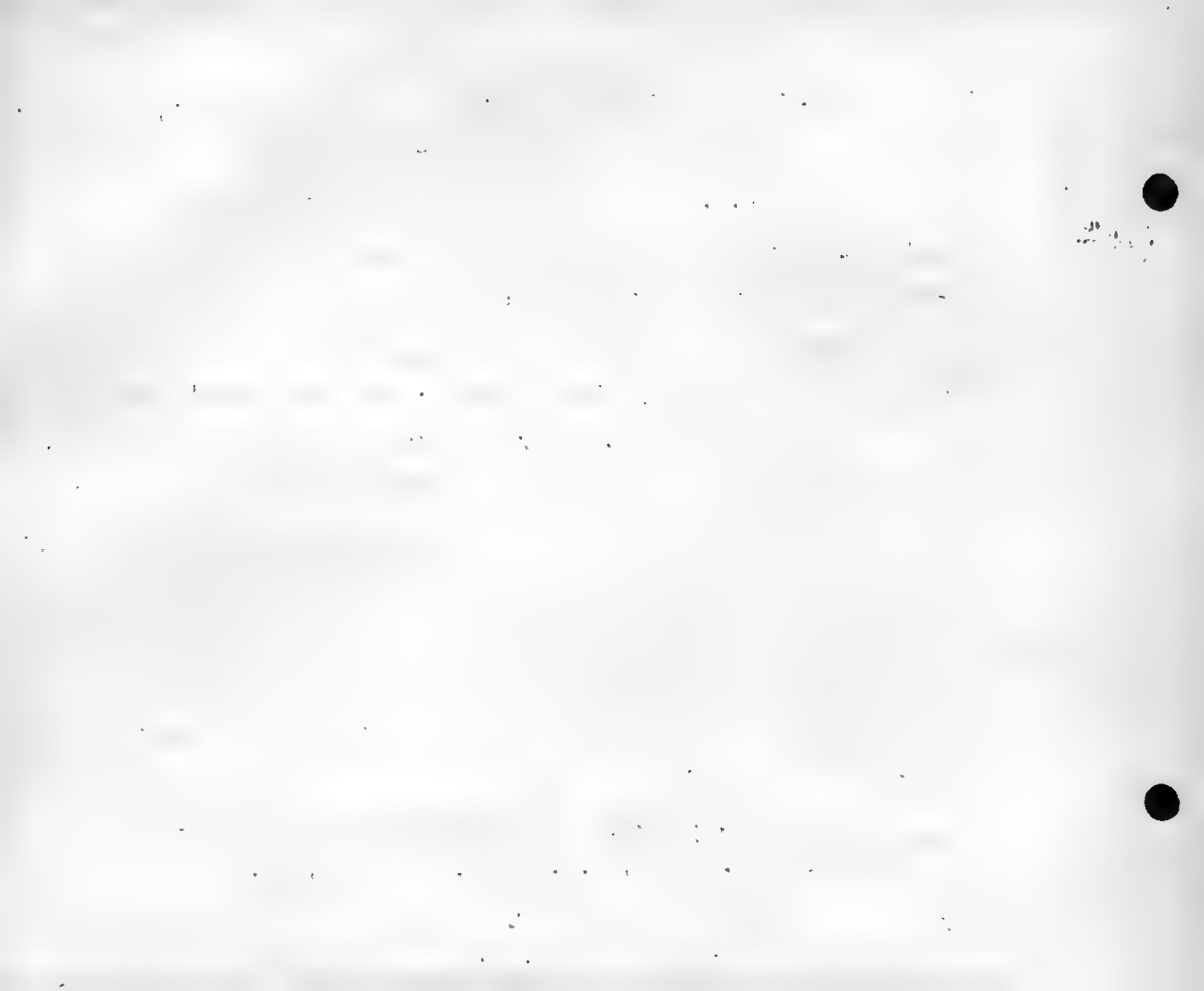
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1 DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR	
LISA ANNETTE HUTCHINSON					JAN Month 6 Day 1969 Year			4:48p M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		Cau		Jan 5, 1969		YRS.		1	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Anne Arundel		USA				Anne Arundel Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Ft Geo G. Meade		U.S. Kimbrough Army Hosp		None		None			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Prince Georges		Landover YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3507 Dodge Pk Rd, Apt 202			
14 FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME		First	Middle	Lost
Carl F. Hutchinson					Thelma Beliflower				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
No		None		Landover, Md Carl F. Hutchinson, 3507 Dodge Pk Rd, Apt 202					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY DISTRESS SYNDROME</u>								1 DAY	
7762 DUE TO, OR AS A CONSEQUENCE OF (b) <u>LOW BIRTH WEIGHT FOR GESTATIONAL AGE</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>5 Jan</u> , 19 <u>69</u> , to <u>6 Jan</u> , 19 <u>69</u> , that <del>he</del> (we) last saw the deceased alive on <u>6 Jan</u> , 19 <u>69</u> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <u>William J. Weston MD</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6 January 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>WILLIAM L. WESTON, CPT, MC,</u>				22e. ADDRESS <u>US KIMBROUGH ARMY HOSP, FT MEADE, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/8/69		Garden of Memory, <del>Fla</del>		Florence, South Carolina			
24. FUNERAL DIRECTOR <u>Howard County Funeral Home of Harry H. Witzke</u>				ADDRESS <u>Ellicott City, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 8 1969</u>		25b. REGISTRAR'S SIGNATURE <u>J. C. Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last <b>William Matthew Johnson</b>						2a. DATE OF DEATH Month Day Year <b>January 21 1969</b>			2b. HOUR <b>7 P.M.</b>		
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-13-1875</b>		6. AGE (in years last birthday) <b>93</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.					
10. CITY OR TOWN OF DEATH <b>Tracy's Landing</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route #2-Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farming</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Tracy's</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>none</b>	
14. FATHER'S NAME First Middle Last <b>Uriah Johnson</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Alice Mayhew</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO <b>219-54-4888</b>		17. INFORMANT (Son) Address <b>James W. Johnson Tracy's Landing</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1969</b> , to <b>Jan 21, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 21, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Willard F. Smith</b>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-22-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Willard F. Smith, M.D.</b>				22e. ADDRESS <b>Shady Side, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/24/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St James Episcopal</b>		23d. LOCATION (City or Town) (County) (State) <b>Lothian, Md</b>					
24. FUNERAL DIRECTOR <b>Hutchins Funeral Home, Owings, Md.</b>				25a. REC'D BY REGISTRAR DATE: <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
CLARENCE P. JONES						1 12 189		5:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	White	3/4/1893	75 ? YRS			January 12 1969		5:30 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Cintra, Va.		U. S. A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Glen Burnie <del>Annapolis</del>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Dorsey Rd. (back of 1913--)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
						Operator		Plastic	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			A. A.			Glen Burnie <del>Annapolis</del>		Back of 1913 Dorsey Rd.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Charles Henry Jones				Elizabeth Catherine Lampkin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
Yes			World War 1		229-14-2425 William W. Owens 163 Whitney Landing				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Edward F. Wilson, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 1/13/69	
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/16/1969		Baltimore National		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. RECD BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Raymond C. Fink Glen Burnie, Md.				JAN 16 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR A. M.	
Grace			Jones			1 5 1969			6:40 A.	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		2/??/1903			66? YRS.		-- --	
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Unknown			Unknown			Anne Arundel			Md	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Laurel			D.C. Children's Center Hospital			Institutionalized			-	
13a USUAL RESIDENCE (Where deceased admission) STATE			13b COUNTY			13c CITY OR TOWN			13e STREET AND NUMBER	
Unknown			Unknown			Unknown			Unknown	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Unknown			Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b SOCIAL SECURITY NO.			17 INFORMANT Address				
No			None			Children's Center Hospital, Laurel, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Aspiration of Gastric Contents</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/25/41</u> to <u>1/5/69</u> , that (I) (we) last saw the deceased alive on <u>1/5/69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Rolando V. Goco, M.D.</u>						22c DATE SIGNED <u>1-6-69</u>				
22d PHYSICIAN'S NAME (Type)						22e ADDRESS				
Rolando V. Goco, M.D.						Children's Center Hospital Laurel, Md.				
23a BURLING, CREMATION, REMOVAL (Specify)			23b DATE <u>1/9/69</u>		23c NAME OF CEMETERY OR CREMATORY <u>Children's Center</u>		23d LOCATION (City or Town) (County) (State) <u>Laurel</u> <u>AAACo</u> <u>Md</u>			
24 FUNERAL DIRECTOR <u>Ronald W. Goco, M.D.</u>						25. REGD BY REGISTRAR DATE <u>JAN 13 1969</u>		25d REGISTRAR'S SIGNATURE <u>Rolando V. Goco</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

00178

00178

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
IRA		S	JONES		1		24	1969		7 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS	8 MONTHS	9 DAYS	10 HOURS	11 MIN	2c DATE PRONOUNCED DEAD	
M	W	12-27-12	56 YRS						Month	Day
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10		
W V A.		U S A.				A. A. CO.		Md.		
11 CITY OR TOWN OF DEATH		12 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		13a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		14b KIND OF BUSINESS OR INDUSTRY		15		
Glen Burnie		JOA-Month. Arundel		MAINT.		UTILITIES				
13a USUAL RESIDENCE (Where deceased lived, if not institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		16
MD		A. A.		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		416 Ritchie Hwy.		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	16	
JAMES		W.	JONES		ADA		?	WHITE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		18		
YES		233 07-7138		Mrs. Margaret Jones		As Above				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerosis generalized</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED
<i>[Signature]</i>		E. Linhardt						124.69		
				ADDRESS (Street, city, town, or county)		A. A. CO.				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		1/29/69		Arlington National		Arlington, Virginia				
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Raymond C. Fink				Glen Burnie, Md.		DATE JAN 29 1969		<i>[Signature]</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00180										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00179													
1 DECEASED NAME (Type or print) First Middle Last Essie G. JUMP										2a. DATE OF DEATH Month Day Year JANUARY 6 1969										2b HOUR 5 <sup>00</sup> A M													
3 SEX Female		4 RACE White		5 DATE OF BIRTH June 24, 1885				6 AGE (In years last birthday) 83 YRS				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN																			
7a BIRTHPLACE (State or foreign country) Virginia				7b CITIZEN OF WHAT COUNTRY? U.S.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Anne Arundel County Md.																					
10. CITY OR TOWN OF DEATH Glen Burnie Md				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) No. Arundel Conv. Center				12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY																					
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND				13b COUNTY Anne Arundel				13c CITY OR TOWN SEVERN PARK				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 46 Boone Trail																			
14. FATHER'S NAME First Middle Last — SELF —										15 MOTHER'S MAIDEN NAME First Middle Last — MARTHA JONES —																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown				16b SOCIAL SECURITY NO. —				17. INFORMANT Woodrow S. Harrison 46 Boone Trail, Severn Park, Md																									
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHF 4124 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute 1/6/69																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																	
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)										21f LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from Nov 18, 1965, to Jan 5, 1969, that (I) (we) lost saw the deceased alive on Jan 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																	
22b SIGNATURE J. L. I. Stern										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c DATE SIGNED 1/6/69													
22d PHYSICIAN'S NAME (Type)										22e ADDRESS																							
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE Jan 8, 1968				23c NAME OF CEMETERY OR CREMATORY Oliver Cemetery										23d LOCATION (City or Town) (County) (State) St. Michaels Talbot Md									
24. FUNERAL DIRECTOR Harrison E. Leonard										ADDRESS St. Michaels Md										25a REC'D BY REG-STRAR DATE Jan 9 1969				25b REG-STRAR'S SIGNATURE Charles J. J...									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year		2b. HOUR
HERMAN K. JUPITZ						19 69			9:10		
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	April 21, 1926	42 YRS					January 9, 19 69		9:10	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U. S. A.				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			North Arundel Hospital			Stevenson					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			A. A.		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 83 E. Rt 10 Pasadena, Md.		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Carl Jupitz				Anna Walk							
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
Yes			214-20-4306		Mrs. Pauline Jupitz			Route 10 Box 83 E Pasadena, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Isopropyl Alcohol intoxication											
8539 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			2 P.M. 1 6 19 69			Subject ingested isopropyl alcohol					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
		Home			Box 83 Rt. 10 Pasadena A. A. Md.						
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			M.D.			22b. DATE SIGNED		
Edward F. Wilson			Edward F. Wilson, M.D.						1/9/69		
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			1/12/69		Cedar Hill Cemetery			Baltimore, Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Charles L. Stevens Funeral Home, Inc.			1501 East Fort Avenue			JAN 14 1969			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Lost	2a DATE OF DEATH Month Day Year		2b HOUR	
PETER EDWARD KAIROS						JANUARY 21 1969		1:22 P M	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		DECEMBER 17, 1926		42 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
MARYLAND		USA				ANNE ARUNDEL			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b K ND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL GENERAL		UPHOLSTERER		UPHOLSTERY			
13a JSJAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		BALTIMORE						884 MILDRED AVE	
14 FATHER'S NAME			First	Middle	Lost	15 MOTHER'S MAIDEN NAME			First Middle Lost
GEORGE KAIROS						VIOLET STANELY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address
NO			220 20 5956			DEBORA E. KAIROS (wife)			SAME AS #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>									2 days
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart and pulmonary edema</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>A. S. C. V. D.</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (1) (this hospital) attended the deceased from Jan 19, 1969, to Jan 21, 1969, that (1) (we) last saw the deceased alive on Jan 21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b SIGNATURE Robert Dabolins MD					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Jan 21, 1969
22d. PHYSICIAN'S NAME (Type) ROBERT DABOLINS, MD					22e. ADDRESS 400 Chain Bridge Rd Glen Burnie, Md				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
BURIAL		JAN. 24/69		GLEN HAVEN MEMORIAL PARK		GLEN BURNIE, MD.			
24 FUNERAL DIRECTOR R. Singleton		SINGLETON FUNERAL HOME		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
		GLEN BURNIE, MARYLAND		DATE JAN 23 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00182											
1. DECEASED-NAME (Type or print) First Middle Last EDGAR LEE Keiter						2a. DATE OF DEATH Month Day Year January 6 1969			2b. HOUR 10 17 PM		
3 SEX MALE		4. RACE white		5. DATE OF BIRTH April 14, 1897		6 AGE (In years lost birthday) 71 YRS		7. UNDER YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Silk Mill					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN ODENTON		13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1610 Annapolis Rd			
14. FATHER'S NAME First Middle Last Frederick Theodore Keiter				15. MOTHER'S MAIDEN NAME First Middle Last Lucinda (unknown) Clark							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-07-4919 (wife)		17. INFORMANT Mrs. Anita Keiter Address 1610 Annapolis Rd Odenton Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CRUSHED L-1 VERTEBRAE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 21, 1968, to Jan 6, 1969, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE T.C. Callis MD						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) T.C. Callis MD						22e. ADDRESS Hahn Professional Building Building Street and					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		JAN. 9 1969		MEADOWRIDGE MEM. PK.		ELK Ridge Maryland					
24. FUNERAL DIRECTOR EB. Fleming		ADDRESS SINGLETON FUNERAL HOME		25a. REC'D BY REGISTRAR JAN 8 1969		25b. REGISTRAR'S SIGNATURE H. Charles Young					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

VR A15  
45M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00183									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P.
Douglas Stokes KING						January 14 1969			1:15 PM
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		7 IF UNDER 1 YEAR MONTHS DAYS
Male		Negro		Dec. 13, 1905			63 YRS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Connecticut		U.S.					Anne Arundel Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Annapolis			Anne Arundel Gen. Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Maryland			Anne Arundel		Annapolis				Rt-3, Arundel on the Bay
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
James V. King			Anna J. Noble						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
					Vandela H. King Annapolis Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Thrombosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. T. Allen</u>						22c DATE SIGNED			
22d PHYSICIAN'S NAME (Type) <u>A. T. Allen, M.D.</u>						22e ADDRESS <u>62 Cathedral St., Annapolis, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <u>1-18-1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Bolling Hill Cem</u>			23d LOCATION (City or Town) (County) (State) <u>Princess Anne Md</u>		
24 FUNERAL DIRECTOR <u>H.S. Washington &amp; Son</u>				ADDRESS <u>4925 Dean St</u>		25a REC'D BY REGISTRAR <u>Jan 20 1969</u>		25b REGISTRAR'S SIGNATURE <u>Richard Judge</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film 009

1/29/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
00185 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00184

1 DECEASED-NAME (Type or Print) Howard V. King			2a DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> 1 17 1969			2b HOUR 11:00 AM		
3 SEX Male	4 RACE C	5 DATE OF BIRTH 12/25/1915	6 AGE (n years last birthday) 53 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 1 17 1969		
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County		
10. CITY OR TOWN OF DEATH Jessup		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Md. House of Correction		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unemployed		12b KIND OF BUSINESS OR INDUSTRY None		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN —		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME John			15. MOTHER'S MAIDEN NAME ETIA		13e. STREET AND NUMBER no permanent address			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) unk.		17. INFORMANT Helen Bailey		ADDRESS 1215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) 22b DATE SIGNED Jan 18, 1969								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 1-12-69		23c. NAME OF CEMETERY OR CREMATORY M.T. Auburn		23d LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR MORTON & Dyett F.H. Inc. 1701 LAURENS				ADDRESS		25a REC'D BY REGISTRAR DATE JAN 20 1969		25b REGISTRAR'S SIGNATURE Charles J. Jones



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6, Film #11 4/7 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03325

1 DECEASED-NAME (Type or Print) <b>Rev. First Middle Last C.S.S.R. THOMAS KOZLOVSKY</b>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>1 13 69</b>		2b. HOUR <b>P</b>
3 SEX <b>M</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>1/19/09</b>	6 AGE (in years) <b>160</b> YRS	7c. DATE PRONOUNCED DEAD Month <b>3</b> Day <b>30</b> Year <b>1969</b>
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>ANNE ARUNDEL CO</b>		Md.		
10 CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WEEKS CREEK</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PRICEY PHOTOGRAPHER</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO. - BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME First Middle Last <b>Thomas Kozlovsky</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Mary Kaspar</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Rev. Vincent Crotty, 2111 Ashland Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Striking</b> <b>9109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>First Farm.</b>		21f. LOCATION Street or R.F.D. No City or Town County State <b>South River - Anne Arundel Co.</b>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>E. Linhardt</b>		22b. DATE SIGNED <b>3/30/69</b>		
EXAMINER'S NAME (Type) <b>E. Linhardt</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>BALCO</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/2/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Schimmunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>		25a. REC'D BY REGISTRAR <b>APR 2 1969</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b. HOUR		
William Frederick Krahling						January 8, 1969			M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		12/27/1894		74 YRS					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Balto. Co. Md			U. S. A.						Anne Arundel Md		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Glen Burnie, Md.			North Arundel Genl Hosp			Ret. Supervisor U. S. Coast Guard					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			13b COUNTY			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3808 4th Street 21225	
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
Hertman Krahling				Johanna Niemann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
No			217-34-5035			Mrs. Lillian M. Krahling			3808 4th St. 21225		
18. CAUSE OF DEATH (Enter an y one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction											
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerotic heart disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
none											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 12/20, 1965, to 1/8, 1969, that (I) (we) last saw the deceased alive on 1/29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE R.M. McLaughlin						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 1/9/69		
22d PHYSICIAN'S NAME (Type) R.M. McLaughlin						22e ADDRESS 5705 Mountain Rd. Pasadena, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			1/11/69		Cedar Hill			Ritchie Hwy Anne Arundel Co.			
24. FUNERAL DIRECTOR McCully F.H.						ADDRESS 237 Patapsco Ave. 21225			25a REG BY REGISTRAR JAN 13 1969		
									25b REGISTRAR'S SIGNATURE		

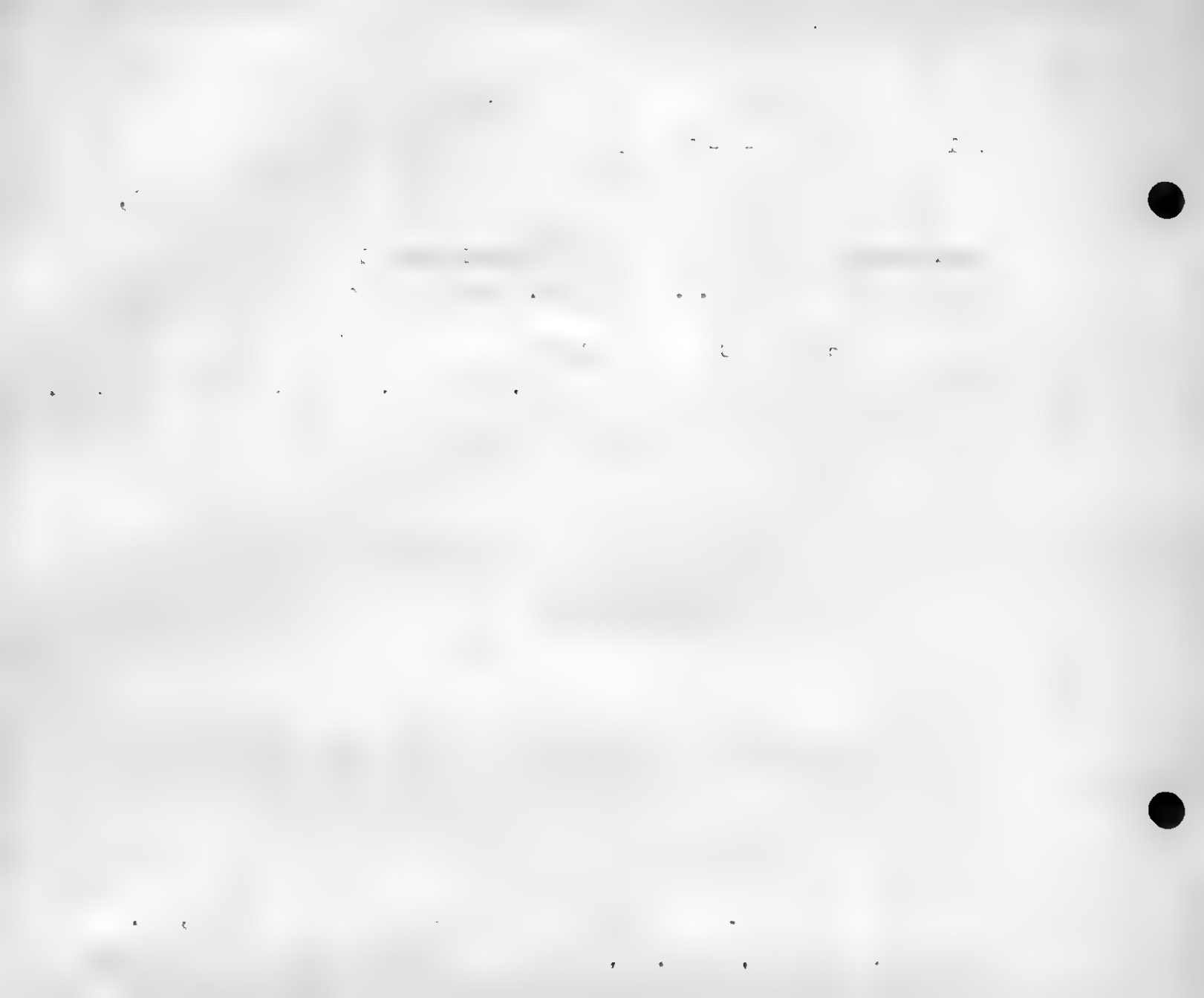


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																							
1 DECEASED NAME (Type or Print)			First <b>HERBERT</b>			Middle <b>Charles</b>			Last <b>KULENEK</b>			2a DATE KNOWN OF DEATH EST MATED <input type="checkbox"/> 1 30 69 <sup>9</sup>			2b HOUR <b>A</b> M								
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>7-29-67</b>		6 AGE (in years last birthday) <b>18 mo</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 1 Day 30 Year 19 69			2d HOUR <b>A</b> M								
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>				7b CITIZEN OF WHAT COUNTRY? <b>USA</b>				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Anne Arundel,</b> Md.											
10 CITY OR TOWN OF DEATH <b>Glen Burnie</b>				11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) <b>North Arundel Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>None</b>				12b KIND OF BUSINESS OR INDUSTRY											
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>				13b COUNTY <b>A.A.</b>				13c CITY OR TOWN <b>Glen Burnie</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>1708 Leisure Lane</b>											
14. FATHER'S NAME			First <b>Richard</b>			Middle <b>C</b>			Last <b>KuleneK</b>			15. MOTHER'S MAIDEN NAME			First <b>Catherine</b>			Middle <b>Smith</b>			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mr. Richard C. KuleneK, Riviera Beach, Md.</b>				ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute upper respiratory infection</u> <b>5089</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sharon</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion an death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <b>E. Linhardt</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>1.3.69</b>															
EXAMINER'S NAME (Type) <b>E. Linhardt</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>															
ADDRESS (Street, city, town, or county) <b>Baltimore, Md.</b>				23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>				23b DATE <b>2/3/69.</b>															
23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>				23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>				24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>															
ADDRESS <b>Baltimore, Md.</b>				25a REC'D BY REG STRAR <b>JAN 31 1969</b>				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00186

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00187

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) aka Ruth Middle white Marie Last LEE		2a DATE OF DEATH Month Day Year January 11 1969		2b HOUR A. 9:45 M
3 SEX Female	4 RACE White	5. DATE OF BIRTH Sept. 29, 1915		6 AGE (In years lost birthday) 53 YRS
7a BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel		Md		
10. CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dead on arrival Anne Arundel Gen. Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) roll mach. operator
12b KIND OF BUSINESS OR INDUSTRY City Gov't				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel	13c CITY OR TOWN Annapolis	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e STREET AND NUMBER 23 State Circle				
14 FATHER'S NAME First Middle Last Joseph White		15 MOTHER'S MAIDEN NAME First Middle Last Cecilia Gregg		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no		16b SOCIAL SECURITY NO 245-02-9833	17 INFORMANT Augustine J. Lee - same as #13 above	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC CIRRHOSIS DUE TO, OR AS A CONSEQUENCE OF (c) 511.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 10 YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 6-20, 1936 to 1-11, 1969, that (I) (we) last saw the deceased alive on 1-11-1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death				
22b SIGNATURE Edward S. Beck MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 1-11-69
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22e ADDRESS 73 Franklin St., Annapolis, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 1/14/69	23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION (City or Town) Annapolis		(County) Anne Arundel		(State) Md.
24. FUNERAL DIRECTOR HOPPING FUNERAL HOME - ANNAPOLIS, MD.		25. REG'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last EVA NMN LEGUM			2a. DATE OF DEATH 1 Month 11 Day 69 Year		2b. HOUR 3 P M	
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH 8-7-88		6 AGE (In years lost birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel Md			
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) never worked		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md		13b. CITY OR TOWN Annapolis		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 109 Lumbert Ave.			
14 FATHER'S NAME First Middle Last Joseph Goldberg			15 MOTHER'S MAIDEN NAME First Middle Last Anna Fishman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO 217-14-5890		17 INFORMANT Donald Levy		Address: Silver Springs, 225 Highland Drive, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LEUKEMIA.								6 months	
DUE TO, OR AS A CONSEQUENCE OF (b) CVA.								2 days	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12-21, 1968, to 1-11, 1969, that (I) (we) last saw the deceased alive on 1-11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Adeleke Adeyemo					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-11-69		
22d. PHYSICIAN'S NAME (Type) ADELEKE ADEYEMO					22e. ADDRESS Annapolis, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/12/69		23c. NAME OF CEMETERY OR CREMATORY Knesset Israel Cemetery		23d. LOCATION (City or Town) Annapolis		(County) (State)	
24. FUNERAL DIRECTOR E. Hopping HOPPING FUNERAL HOME - Annapolis, Md					25a. REC'D BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

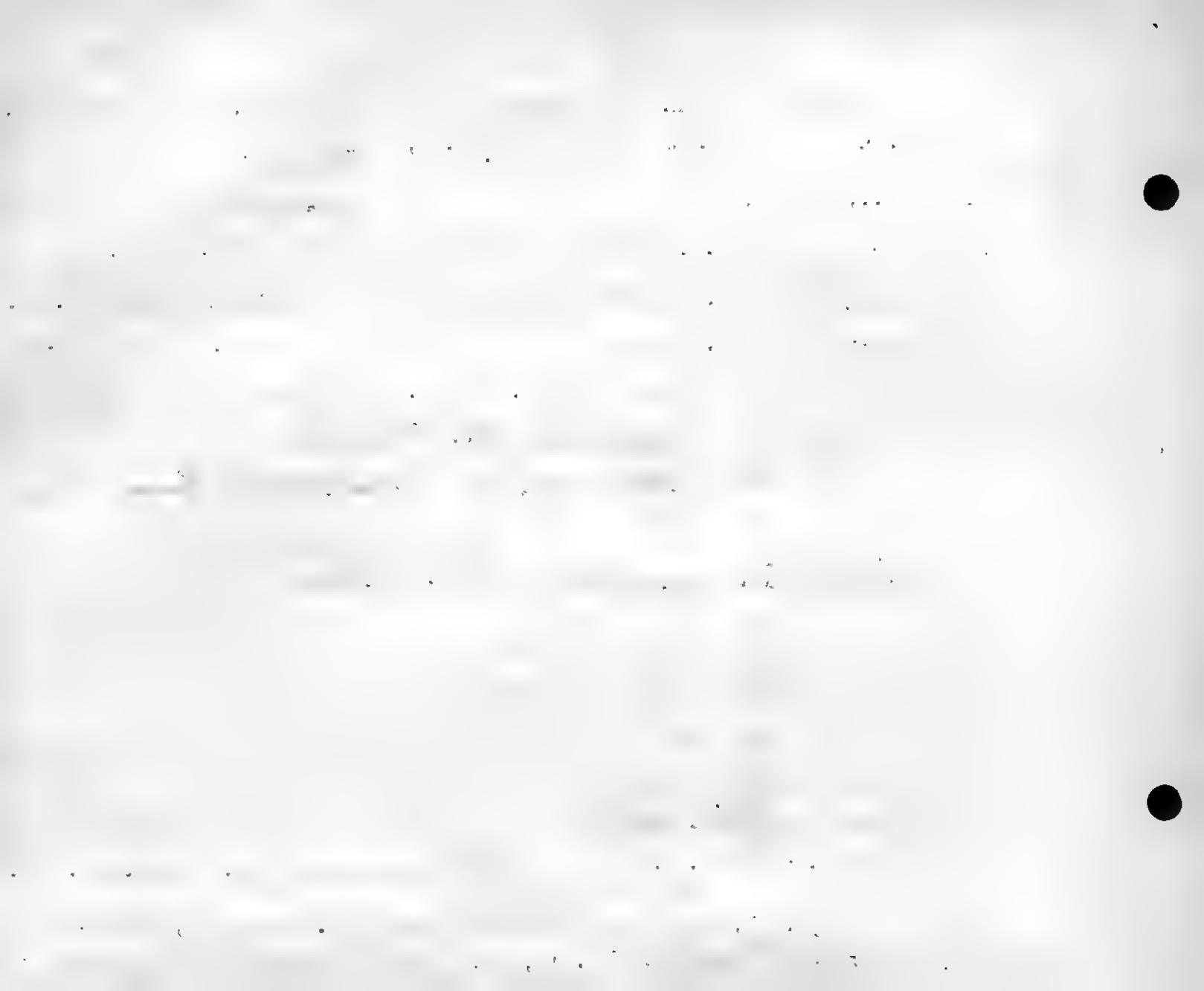
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00190

00189

1. DECEASED NAME (Type or print) <b>Carroll R. Logue</b>			2a. DATE OF DEATH Month <b>Jan.</b> Day <b>14</b> Year <b>1969</b>			2b. HOUR <b>12:50 AM</b>								
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 3, 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>				
7a. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Anne Arundel</b> Md					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>A.A. General Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Machinist (ret.)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Civil Service</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Severna Pk</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>Box 4002, Manhattan Bch. Rd.</b>		
14. FATHER'S NAME First Middle Last <b>James A. Logue</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Rosie A. Collins</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I &amp; II</b>			16b. SOCIAL SECURITY NO. <b>219-28-5460</b>			17. INFORMANT <b>Mr. Paul C. Louge (brother)</b> Address <b>Box #20 Millersville,</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concurrent Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 day</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>① Diabetes mellitus ② arthritis</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Ray M. Smith, M.D.</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>1/14/69</b>					
22d. PHYSICIAN'S NAME (Type) <b>Ray M. Smith, M. D.</b>						22e. ADDRESS <b>Hahn Professional Bldg., Severna Pk., Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Jan. 17, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Church of God Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Warfieldsburg, Maryland</b>					
24. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>						ADDRESS <b>Allen Burnie, Md.</b>			25a. REC'D BY REGISTRAR <b>JAN 17 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 409 1-24-69 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00192					00190					
1 DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
Grace I. Lower					1 Month 6 Day 1969		10:50 AM			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
female		W		5-18-11		57 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			No. Arundel Hospital			Housework		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution on Res. dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM IT? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Glen Burnie		YES <input type="checkbox"/> NO <input type="checkbox"/>		7519 Oakwood Road	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Basil Johnson					(unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no			220 10 7660		Mr. Carl A. Lower (husband) Same As #13					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Failure</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of liver</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Bronchopneumonia</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30-</u> , 19 <u>68</u> , to <u>1-6-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-6-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Henry M. Wiley MD</u>									1-7-69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
					Oakwood Rd. Glen Burnie, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		Jan. 10, 1969		Glen Haven Memorial Park		Glen Burnie, Maryland				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>R. L. Singleton</u>					DATE		<u>13 1969</u>			
Glen Burnie, Maryland										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day, Year		2b HOUR M	
BUELAH			NAOMI			MANTHE		JANUARY 9, 1969	
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		APRIL 25, 1905		63 YRS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10 CITY OR TOWN OF DEATH	
MARYLAND		U.S.A.				ANNE ARUNDEL		GLEN BURNIE	
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b CITY OR TOWN	
NORTH ARUNDEL HOSP.		MACHINE OPERATOR		HAT FACTORY		MARYLAND		MILLERSVILLE	
14. FATHER'S NAME First Middle Last		15 MOTHER'S M.A.DEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address	
JOHN C. WOOD		MARY E. MARTIN				214 03 0931		MRS. ROSE NAPIER (sister) MILLERSVILLE, MD.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>									
4123 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, POLICE BUILDING, ETC.)		21f. LOCATION Street or RFD No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from 1/10, 1968, to 1/8, 1969, that (I) (we) last saw the deceased alive on 1/8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Samuel Rubin		1/10/69		Samuel Rubin, M.D.		203 E. Patapsco Avenue Baltimore, Md. 21225			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		23e REC'D BY REGISTRAR	
BURIAL		JAN. 13, 1969		WOODS FAMILY CEMETERY		MILLERSVILLE, MD.		JAN 13 1969	
24 FUNERAL DIRECTOR		25a ADDRESS		25b REGISTRAR'S SIGNATURE		25c DATE		25d REGISTRAR'S SIGNATURE	
R. Singleton		SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND				JAN 13 1969			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Vernon			Martin			DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR		
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7c. COUNTY OF DEATH	
M			W		9/11/20		48 YRS		Anne Arundel	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Md.			U.S.					Anne Arundel		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USJA OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie			North Arundel							
13a. USJA USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER	
Md.			Anne Arundel			Glen Burnie			280 Eleventh St.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.	
						no			218-01-7076	
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Evelyn L. Martin			280 11th. St. Chelsea Beach			PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u>			18 YRS.	
						DUE TO, OR AS A CONSEQUENCE OF (b) _____				
						DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19 P M							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
1-5-69			Pine Grove Balto. Co.			Balto. Co.				
22b. DATE SIGNED										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>Louise Theresa MASSCRO</b>			2a DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1969</b>			2b HOUR <b>8:42</b> P.M.	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>May 21, 1915</b>		6 AGE (n years last birthday) <b>53</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md	
10 CITY OR TOWN OF DEATH <b>Annapolis</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Anne Arundel Gen. Hospital</b>		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY	
3a USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b COUNTY <b>Anne Arundel</b>		13c CITY OR TOWN <b>Annapolis</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <b>111 Edelman Drive</b>		14 FATHER'S NAME First Middle Last <b>Salvatore Battaglia</b>		15 MOTHER'S M.A.D.E.N. NAME First Middle Last <b>Rosario Cascio</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b SOCIAL SECURITY NO <b>219-28-7692</b>		17 INFORMANT <b>Carmello Masscro</b>		Address <b>Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. <b>4107</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute myocardial infarction</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>1 hour</b> <b>2 hours</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerotic cardiovascular disease, coronary &amp; general; diabetes mellitus</b>							
19a DATE OF OPERATION <b>NA</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1968</b> to <b>January 20, 1969</b> , that (I) (we) last saw the deceased alive on <b>January 10, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (d) (d) (d) not view the body after death							
22b SIGNATURE <b>Charles W. Kinzer</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>January 21, 1969</b>	
22d PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M.D.</b>				22e ADDRESS <b>16 Murray Ave., Annapolis, Md. 21401</b> <b>121 Cathedral St., Annapolis, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>1/24/69</b>		23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR <b>Leonard J Ruck Inc, Baltimore, Maryland</b>				25a REC'D BY REGISTRAR <b>JAN 22 1969</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2019

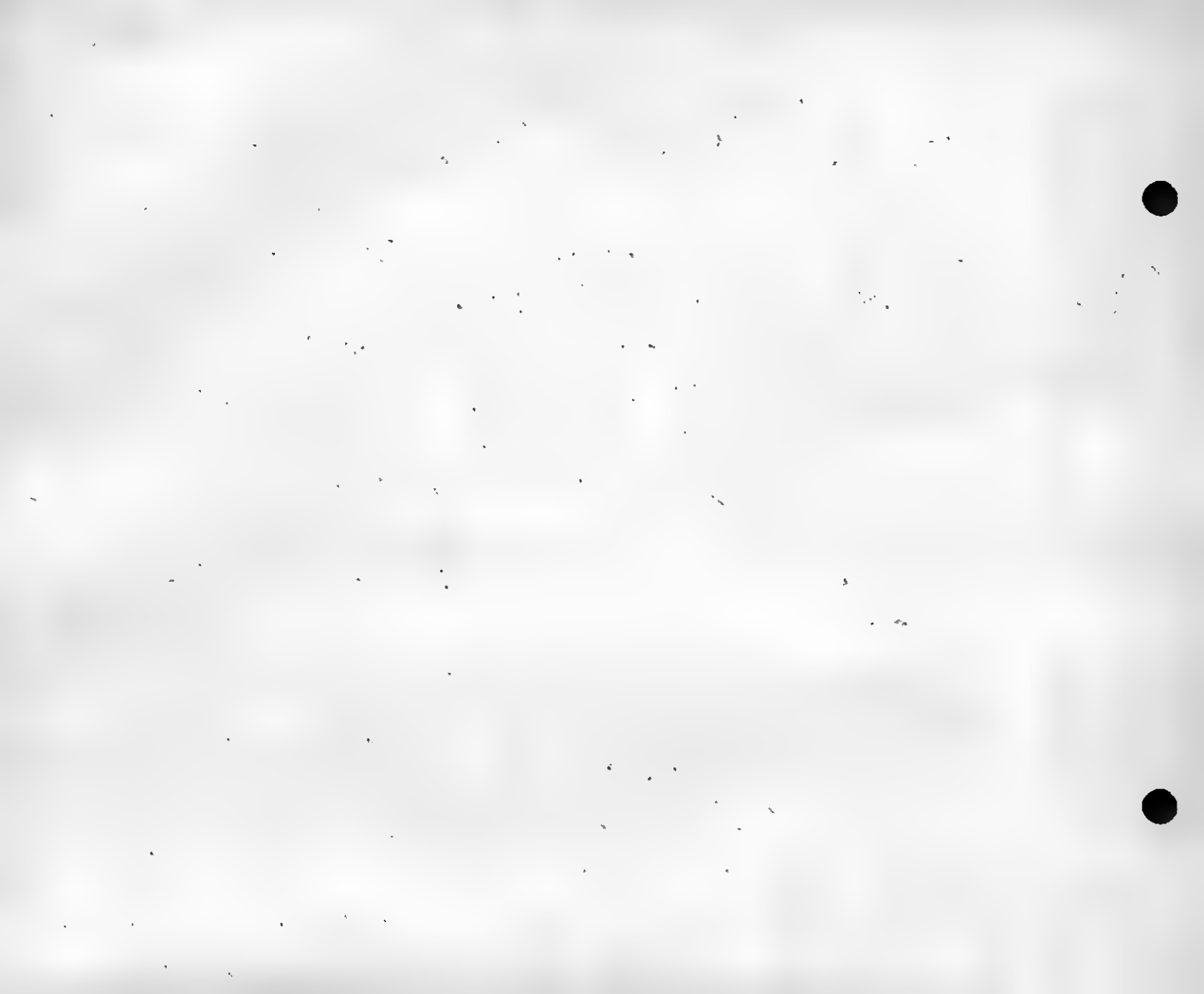
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00194

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Alice Maynard</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>15</b> Year <b>69</b>			2b. HOUR <b>9A</b> M					
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>3/23/1888</b>		6. AGE (In years lost birthday) <b>76</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>12</b> DAYS <b>15</b> HOURS <b>9</b> M.N.			
7a. BIRTHPLACE (State or foreign country) <b>Mid.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.					
10. CITY OR TOWN OF DEATH <b>Tracy Landing</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Tracy Landing</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Mid</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Tracy Landing</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First <b>William</b> Middle <b>Creek</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Christanne</b> Middle <b>Hill</b> Last <b></b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>220 56 1235</b>		17. INFORMANT Address <b>Margaret P. Hill, 1111 Tracy Landing, Md</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>year</b>		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Also had diabetes mellitus</b>											
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b></b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>1</b> Day <b>15</b> Year <b>69</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>No injury</b>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) <b></b>		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>1945</b> to <b>1/14</b> , 19 <b>69</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>1/14/69</b> , 19 <b>69</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.											
22b. SIGNATURE <b>Charles H. Wirth, M.D.</b> DEGREE <b></b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/15/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>CHARLES H. WIRTH, M.D.</b>					22e. ADDRESS <b>LOTHIAN, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b></b>		23b. DATE <b>JAN. 18-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Tr. Carters Church Cem</b>		23d. LOCATION (City or Town) <b>Friend Ship</b>		(County) <b>AA</b>		(State) <b>Md</b>	
24. FUNERAL DIRECTOR <b>Penkney E. Sevell, Prince Georges</b>					25a. REC'D BY REGISTRAR <b></b>		25b. REGISTRAR'S SIGNATURE <b></b>				

JAN 20 1969



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00196

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00195

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH				2b. HOUR	
Joseph F McCarthy						DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 1 18 1969				P M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	12/17/26	42 YRS	MONTHS	DAYS	HOURS	M.I.	Month 1 Day 18 Year 1969		P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				Anne Arundel Co Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			DOA-NORTH ARUNDEL			None			Self Emp.		
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			A.P.C.			Pardonia		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Not Land - Wilks Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Robert J. McCarthy			Mary E. Stuart								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No			578-28-8853			Mary C. McCarthy - (Mother)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease											
DUE TO OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			M.D.			1-15-69					
E. Linhardt						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			A.A.C.W.		
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial			1/22/1969		Meadowridge Memorial Park		Elkridge		Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert E. Jones			Sing Lee Funerals - Glen Burnie			DATE JAN 23 1969			R. E. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00196									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M
Virgie			Lee			McGUIRE			January 2 1969 4:00
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Oct. 31, 1926		42 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Anne Arundel		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Annapolis			Anne Arundel Gen. Hospital			Housewife			Own Home
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Baltimore				7818 Bridge Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John D. Simmons			Virginia Horner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no					David J. McGuire, same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stroke as the mit. inc.</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Brain pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Infarction</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Asphyxia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>17 hrs.</u> <u>four hrs.</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-31, 1968</u> , to <u>1-2, 1969</u> , that (I) (we) last saw the deceased alive on <u>1-1-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frank Murphy MD.</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-2-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>F M MURPHY</u>				22e. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6 Jan. 69		Glen Haven Memorial		Glen Burnie, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Kirkley Funeral Home, Glen Burnie, Md.				JAN 6 1969		<u>[Signature]</u>			

00196 (4)  
1/69



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

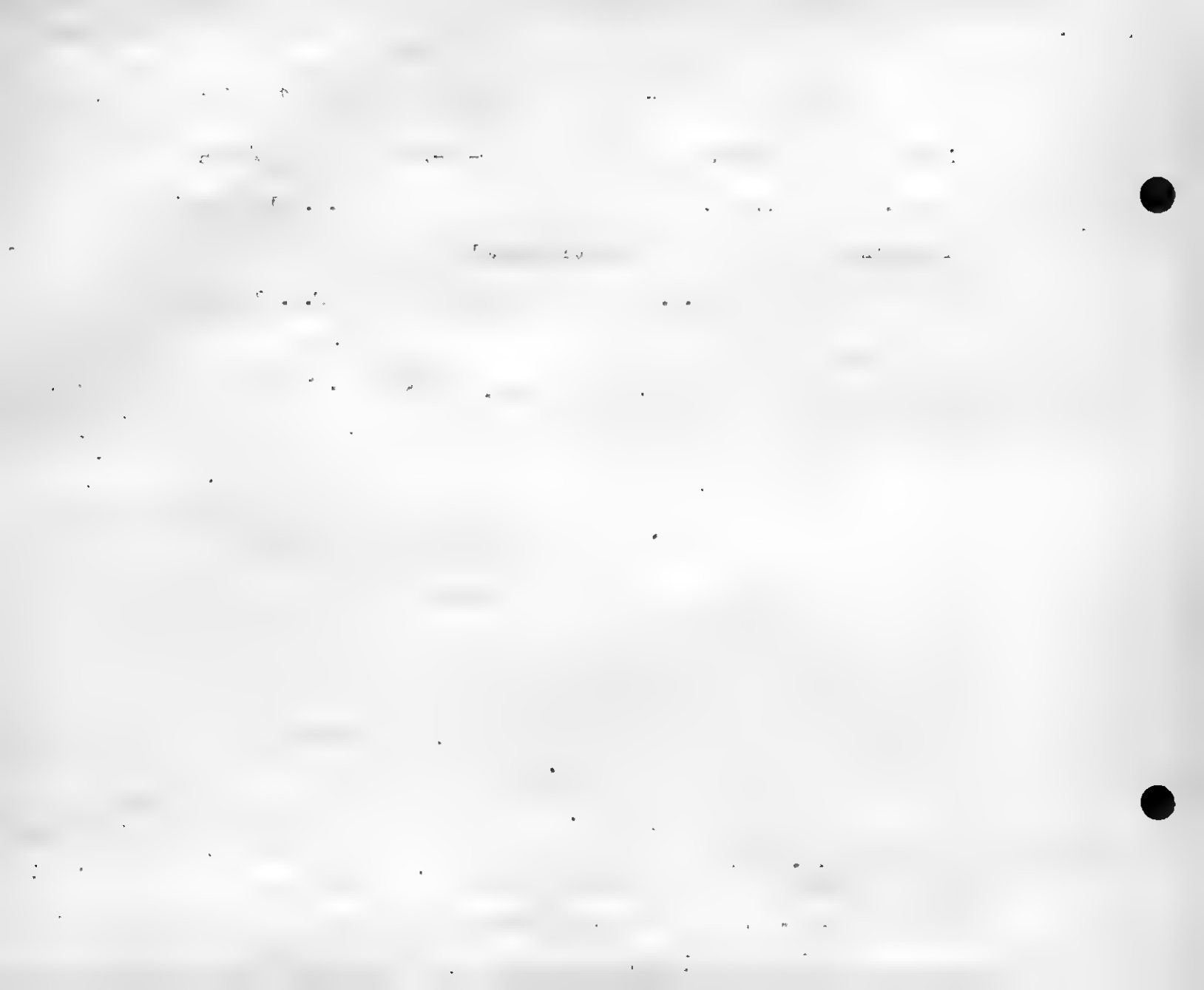
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR		
Catherine			McMillian			1 16 69		1:40 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		
Female		Negro		1879		90 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
South Carolina		US				Anne Arundel Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville			Crownsville State Hospital							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Balto		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3407 Holmes Avenue	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Henry Miller unknown			Axie unknown Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			none		Hospital Records, Crownsville State Hospital					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastroenteritis - emphysematous</u> 595X DUE TO, OR AS A CONSEQUENCE OF Hemorrhagic cystitis Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>A.S.U.D. 8 Extreme mal nutrition</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/</u> , 19 <u>59</u> , to <u>1/16</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/16/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Alberto Gonzalez</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>Alberto Gonzalez</u>					22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>Jan 21, 1969</u>		<u>St. Ambrose Cem.</u>		<u>Baltimore, Md.</u>				
24 FUNERAL DIRECTOR <u>Williams Funeral Home</u>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>3191 Snowden St</u>					<u>JAN 20 1969</u>		<u>Richard J. Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00198											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <b>MARVIN</b>			Middle <b>-</b>			Last <b>MEADOWS</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>5-26-24 1923</b>			2a. DATE OF DEATH <b>1</b> Month <b>30</b> Day Year <b>69</b> <b>10</b> A M		
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			6. AGE (in years lost birthday) <b>XXX 45</b> RS.		
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>North Arundel</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Guard</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Dennis Detec</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>A.A.</b>			13c. CITY OR TOWN <b>Glen Burnie</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <b>Elmer</b>			Middle <b>Meadows</b>			Last <b>Lucinda</b>			15. MOTHER'S MAIDEN NAME First <b>Wood</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>No</b>			(If yes give war or dates of service) <b>None</b>			16b. SOCIAL SECURITY NO <b>217-16-2193</b>			17. INFORMANT <b>Mrs. Loretta M. Meadows (wife) Same as #1</b>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Left Ventricular failure</b> <b>1969</b> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>Days</b> <b>Year.</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 69</b> , to <b>1/30 69</b> , that (I) (we) last saw the deceased alive on <b>1/30 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. Frank</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/30/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. Frank</b>			22e. ADDRESS <b>425 SE Arden Hwy - Glen Burnie, Md</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Feb. 3, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Maryland</b>		
24. FUNERAL DIRECTOR <b>E. B. Thompson</b>			ADDRESS <b>Singleton Funeral Home</b>			25a. REC'D BY REGISTRAR <b>FILE</b>			25b. REGISTRAR'S SIGNATURE <b>3 1969</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First Pansy		Middle Violet		Last Merryman		2a. DATE OF DEATH 1 Month 8 Day 69 Year 12:40A M	
3 SEX Female		4. RACE White		5. DATE OF BIRTH 5-11-89 1890		6. AGE (in years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH A.A.Co.			
10 CITY OR TOWN OF DEATH Glen Burnie		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) North Arundel Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY A.A.Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 104 Ridge Ave.	
14. FATHER'S NAME First Martin		Middle H.K.		Last PAULSEN		15. MOTHER'S MAIDEN NAME First Blanche		Middle MARSH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If you give year or dates of service) None		17 INFORMANT Mrs. Blanche Albright		Address Pikesville 8, Md 107 Hawthorne Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Ca of bladder carcinoma</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>CVA old. HHS CVD, Decubitus ulcers</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-25-1969</u> to <u>1-8-1969</u> , that (I) (we) last saw the deceased alive on <u>1-8-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. S. Dorkan</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Cenap S. Dorkan M.D.		22e. ADDRESS 325 Hospital Drive, G. Burnie		22c. DATE SIGNED 1-8-69					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 10, 1969		23c. NAME OF CEMETERY OR CREMATORY Pikesville		23d. LOCATION (City or Town) Pikesville		(County) (State)	
24. FUNERAL DIRECTOR Frank H. Newell		ADDRESS Pikesville, Md.		25a. REC'D BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE			

...

...



.

.

...



...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0020

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00200

1. DECEASED-NAME (Type or print) First Middle Last <b>Alice Rairdon MITCHELL</b>			2a. DATE OF DEATH Month Day Year <b>January 13 1969</b>		2b. HOUR P. <b>2:50 M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>June 20, 1905</b>		6. AGE (In years last birthday) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Jew Jersey</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Anne Arundel</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Anne Arundel Gen. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if not tuition, residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Rt-3, Wild Shores</b>	
14. FATHER'S NAME First Middle Last <b>JOSEPH RAIRDON</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>LAURA CLAFFY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214 328 23</b>	17. INFORMANT <b>WILLIAM C. MITCHELL</b>		Address <b>#13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CORONARY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS</b> <b>3 HOURS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>BRONCHIECTASIS BRONCHOPNEUMONIA</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <b>JUNE 1959</b> to <b>13 Jan 1969</b> , that (2) (we) last saw the deceased alive on <b>13 Jan 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edward S. Beck</b>		DEGREE <b>EDWARD S. BECK, M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>1-14-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Edward S. Beck, M.D.</b>		22e. ADDRESS <b>73 Franklin St., Annapolis, Md.</b>			
23a. BURIAL (CREMATION, REMOVAL) (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) <b>Annapolis Md. Md.</b>		
24. FUNERAL DIRECTOR <b>W. J. ...</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>JAN 16 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00201

1 DECEASED NAME (Type or Print) <i>Eugene J Mitchell Jr.</i>		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <i>1 22 1969</i>		2b. HOUR <i>A M</i>
3 SEX <i>M</i>	4. RACE <i>N</i>	5 DATE OF BIRTH <i>3/11-68</i>	6 AGE (in years last birthday) YRS <i>10</i>	7a. DATE PRONOUNCED DEAD Month <i>1</i> Day <i>22</i> Year <i>1969</i>
7b. BIRTHPLACE (State or foreign country) <i>Balt. Md.</i>		7c. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Anne Arundel Co</i>
10 CITY OR TOWN OF DEATH <i>A.A. Co.</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Annapolis Gen'l Hospital</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Infant</i>
13a. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) STATE <i>Md</i> COUNTY <i>V</i>		13b. CITY OR TOWN <i>A.A. Co. Annapolis</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET AND NUMBER <i>Franklin &amp; Gibson Rd.</i>
14 FATHER'S NAME First <i>Eugene</i> Middle <i>Mitchell</i> Last <i>Mitchell</i>		15 MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>E.</i> Last <i>Wallace</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16b. SOCIAL SECURITY NO <i>-0-</i>		17 INFORMANT ADDRESS <i>Mr. Eugene Mitchell Same</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute upper Respiratory Inf. Sars</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>465X</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month Day, Year HOUR A.M. _____ P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion				
ACTUAL SIGNATURE <i>E. Howard St.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>1. 22 - 69</i>
EXAMINER'S NAME (Type) <i>E. Howard St.</i>		ADDRESS (Street, city, town or county) <i>AMCO.</i>		
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1/22/69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Balt. Nat'l. Cem.</i>	23d. LOCATION (City or Town) <i>Baltimore</i>	(County) _____ (State) <i>Md</i>
24. FUNERAL DIRECTOR <i>Morton &amp; Dyck F.H.</i>		ADDRESS <i>1701 Laurens St.</i>		25a. REC'D BY REGISTRAR <i>JAN 24 1969</i>
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ☒ use carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4-71

2020

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00202

1 DECEASED-NAME (Type or print) <b>EDWARD FRANCIS Monaghan</b>			2a DATE OF DEATH <b>January</b> Month <b>29</b> Day <b>1969</b> Year		2b HOUR <b>7:35</b> PM
3. SEX <b>MALE</b>	4 RACE <b>CAU</b>	5 DATE OF BIRTH <b>June 7, 1911</b>		6 AGE (In years last birthday) <b>57</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Penn</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Anne Arundel Co Md</b>		
10 CITY OR TOWN OF DEATH <b>Arnold</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RT 2 Box 35-8</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Auditor</b>	12b KIND OF BUSINESS OR INDUSTRY <b>State of Md</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Anne Arundel</b>	13c CITY OR TOWN <b>Arnold</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>RT 2 PO Box 358</b>	
14 FATHER'S NAME First Middle Last <b>Thoms Joseph Monaghan</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>MARY Veronica Scully</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <b>YES</b>		16b SOCIAL SECURITY NO <b>1-179-183189</b>		17 INFORMANT <b>FRANCIS MONAGHAN</b> Address <b>RT 2 Box 358 Arnold Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASCITES + EDEMA</b> <b>710</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis of Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>ALCOHOLISM</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ALCOHOLISM</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 wk</b> <b>one year</b> <b>years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION <b>2/3/69</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ascites + Edema</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR AM Month Day Year <b>PM 19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <b>January 18, 1969</b> , to <b>Jan 17, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 17, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death.					
22b SIGNATURE <b>T.C. Cullen MD</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>29-January 1969</b>	
22d PHYSICIAN'S NAME (Type) <b>T. C. Cullen MD</b>		22e ADDRESS <b>Hahn Professional Building Severna Park</b>			
23a BURIAL, CREMATION, REMOVAL, (Specify)	23b DATE <b>2/3/69</b>	23c NAME OF CEMETERY OR CREMATORY <b>Booth National</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24 FUNERAL DIRECTOR <b>Robert S. Benenard</b>		ADDRESS <b>Severna Park, Md</b>		25a REC'D BY REGISTRAR <b>FEB 9 1969</b>	
				25b REGISTRAR'S SIGNATURE <b>William A. Underwood</b>	

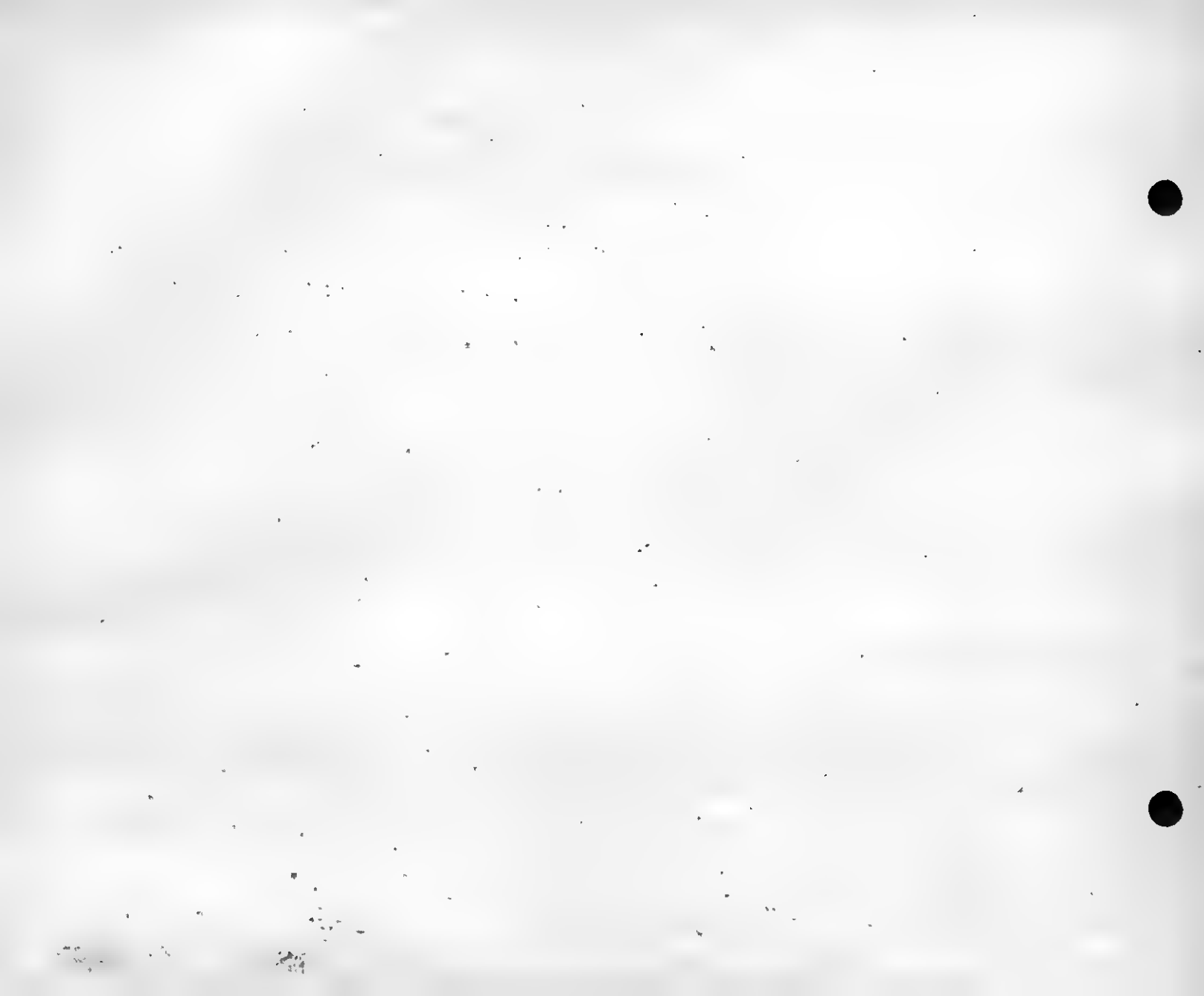


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>ETHEL MAE MOORE</b>			2a. DATE OF DEATH Jan Month 10 Day 1969 Year		2b. HOUR 7:30 P.M.
3 SEX <b>FEMALE</b>	4 RACE <b>COLORED</b>	5. DATE OF BIRTH <b>FEB 15-1927</b>		6 AGE (In years last birthday) <b>41</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ANNE ARUNDEL</b> Md		
10. CITY OR TOWN OF DEATH <b>GLENBURNIE</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>W.H. Lien Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWORK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>	13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>FREETOWN</b>	13d. INSIDE CITY LIM TSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>RT 1-301K</b>	
14 FATHER'S NAME First Middle Last <b>NATHANIEL COTTON</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY ELIA KING</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17 INFORMANT Address <b>DAVID MOORE Rt 1-301K GLENBURNIE</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>410Y</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rheumatic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>none</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1968</b> to <b>Jan 10, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 3, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R.M. McLaughlin, M.D.</b> DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>1/14/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin, M.D.</b>		22e. ADDRESS <b>Paradise, Md. 21122</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>1/15/69</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <b>Haersville S.C.</b>	
24. FUNERAL DIRECTOR <b>Markham P. Hines</b>		ADDRESS <b>638 N. CILMER ST</b>		25a. REC'D BY REGISTRAR <b>JAN 14 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR P	
Charles		G.		Morningstar, Sr.		1		19		7:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		White		7-19-06		62 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.				Anne Arundel		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		North Arundel		retired (Fireman)							
13a. USUAL RESIDENCE (Where deceased lived, if institution, admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Anne Ar.		Glen Burnie				7976 Cross Creek Dr.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Charles P. Morningstar								Rosenia Bishop			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		Drive			
No				Mas. Agnes Morningstar		7976 Cross Creek		Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										Hours	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Coronary Heart Disease</u>										Years	
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1-15-68</u> to <u>1-15-69</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
[Signature]		1-19-69		Henry T. O'Hearty		325 Hospital Drive					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/22/69		New Cathedral Cemetery		Baltimore, "Annapolis"					
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE					
John A. Moran, Inc. 3000 E. Baltimore St.		JAN 22 1969		[Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

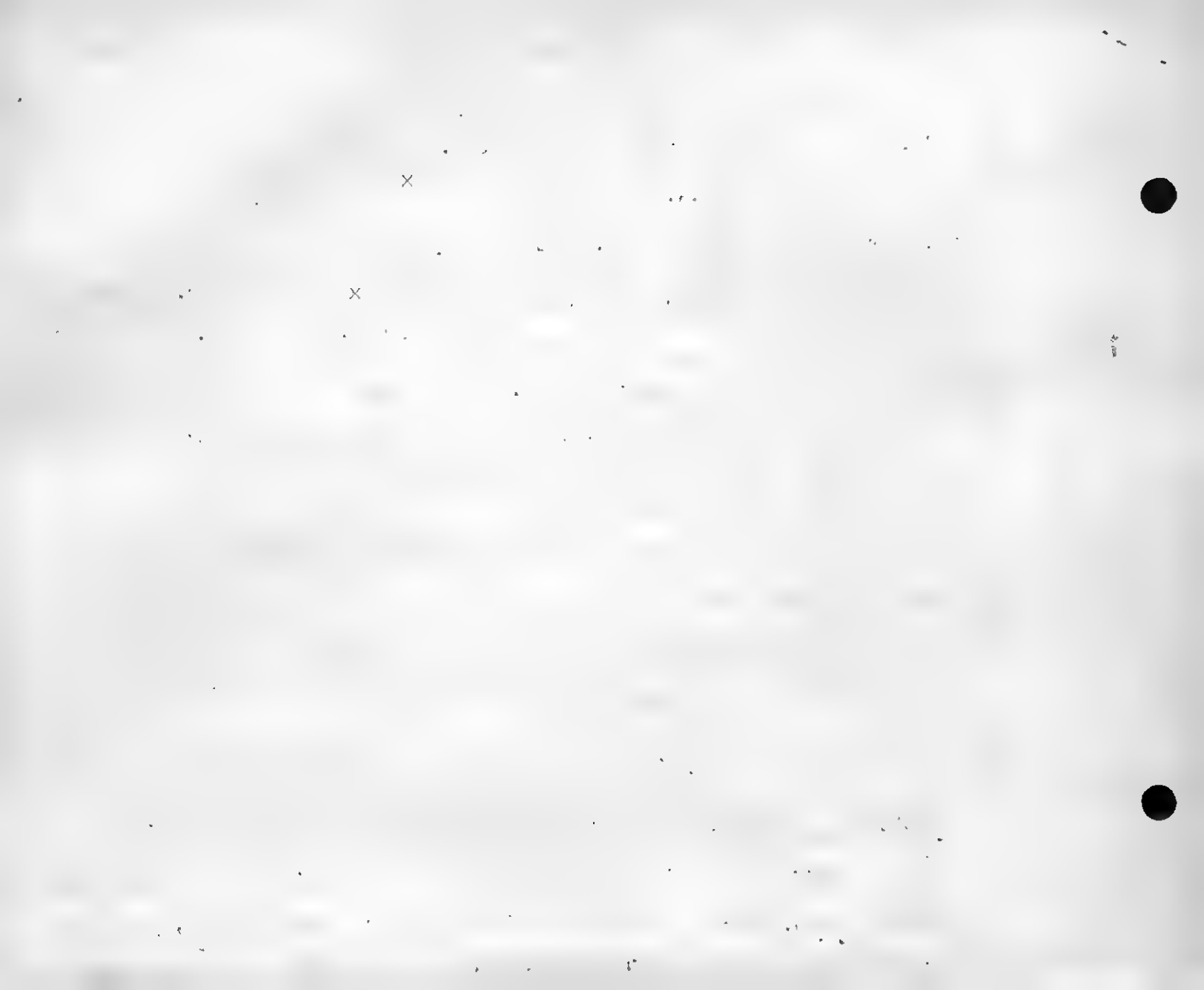
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00200

00205

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Baby Girl				Naumann	1 4 69			1:10 am	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR MONTHS		8. IF UNDER 24 HRS
Female	White		Jan. 3, 1969		YRS.		4 10		10
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland		U.S.A.				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		N. Arundel Hosp.		none		///			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admss on) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Glen Burnie				112 Olan Dr. (Ferndale)	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Howard		Marjorie J. Naumann		no		none		Mr. John Naumann (grandfather) Same As #13	
18. CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity 6 months pregnancy DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity Birth wt 11 lb 11 oz		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/3/1969, to 1/4/1969, that (I) (we) last saw the deceased alive on 1/3/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Allan Y. Wolins, M.D.		1/4/69		ALLAN Y. WOLINS, M.D.					
22e. ADDRESS		22f. ADDRESS							
325 HOSPITAL DR. GLEN BURNIE, MD.									
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 6/69		Glen Haven Memorial Park		Glen Burnie, Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Singleton Funeral Home, Glen Burnie, Md.		JAN 8 1969		J. J. J. J.					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR		
Blanche							Neibert		Month 1 Day 5 Year 48		P M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
F		W		April 11, 1902		66 YRS		MONTHS DAYS HOURS MIN		Month 1 Day 5 Year 1969		P M	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Lithuania			U.S.						Anne Arundel				
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
glen Burnie				SEA-NORTH-Arundel				Seamstress				Johnmuth Co.	
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Md.				A. A.		Tiviera Beach		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8564 Main Ave.			
14. FATHER'S NAME					15 MOTHER'S MAIDEN NAME								
----- Kablis					unknown								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT				ADDRESS	
NO				217-26-6339				Harry Neibert				(same)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer disease</u>											Shore		
4299 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?			
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A.M. P.M. 19										
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No			City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b DATE SIGNED					
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						1-5-69					
E. Linhardt		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						aged					
		ADDRESS (Street, city, town, or county)											
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			1-8-1969		Parkwood Cemetery			Baltimore, Maryland					
24 FUNERAL DIRECTOR						ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
George J. Honce, 4001 Ritchie Hwy., Baltimore									JAN 10 1969		[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A  
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Bernard		Charles		O'Brien				January		3:00 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		April 3, 1911		57 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md	
Maryland		USA		WIDOWED		DIVORCED		Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		Anne Arundel General Hospital		Mechanic							
13a. U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Anne Arundel		Severna Park		YES		380A Arundel Brook Rd			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S M.A.DEN NAME		First Middle Last	
Bernard		(N)		O'Brien				Elizabeth		(N) Brown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address					
NO		216-03-5904		Philip O'Brien		Severna Park					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) PNEUMONIA										8 DAYS	
DUE TO, OR AS A CONSEQUENCE OF											
(b) INFLUENZA										14 DAYS	
DUE TO, OR AS A CONSEQUENCE OF											
(c) ARTERIOSCLEROTIC HEART DISEASE										5 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES		NO			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from Dec 14, 1968, to Jan 5, 1969, that (I) (we) last saw the deceased alive on January 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		T.C. Cullis MD		DEGREE		ATTENDING PHYS		MED. DIRECTOR		STAFF PHYS	
22d. PHYSICIAN'S NAME (Type)		T.C. Cullis MD		22e. ADDRESS		Hahn Professional Building		Severna Park			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		1/8/69		New Cathedral		Balto.				Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Mitchell-Wiedefeld Home		6500 York Rd. #21212		DATE		1969 JAN 8					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Lawrence J. O'Connor, Jr.						1 Month 29 Day 69 Year		8:24 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Male		White		November 4, 1913		55 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		United States				Anne Arundel		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie		North Arundel		Banker		Bank				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Anne Arundel		Linthicum		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		112 Sycamore Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Lawrence J. O'Connor, Sr.			Mary ---- Parkinson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or date of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
Yes <input checked="" type="checkbox"/> (No or unknown) <input type="checkbox"/> W.W.II			220-07-4148		Laura O'Connor, 112 Sycamore Rd., Linthicum					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>									9 months	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
9/3/68		good		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan. 29, 1969 to Jan. 29, 1969, that (I) (we) last saw the deceased alive on Jan. 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (a d) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
Paul J. Chang MD								1/29/69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Paul J. Chang MD				801 Crivley St. Glen Burnie						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2-3-1969		Baltimore National Cem.		Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
George J. Gence, 4001 Ritchie Hwy., Baltimore				FEB 5 1969						



## CERTIFICATE OF DEATH

00209

1 DECEASED NAME (Type or print) <i>James Edward O'Neill</i>			2a DATE OF DEATH Month <i>January</i> Day <i>5</i> Year <i>69</i>			2b HOUR <i>11A</i> M			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>JAN 27 1893</i>		6 AGE (in years last birthday) <i>75</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Illinois</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Albany</i> Md.			
10 CITY OR TOWN OF DEATH <i>Albany</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>St. Mary's</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmer</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i>		13b COUNTY <i>Albany</i>		13c CITY OR TOWN <i>Albany</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <i>ALBION</i> Middle <i>OTIS</i> Last <i>ILL.</i>			15. MOTHER'S MAIDEN NAME First <i>FLORENCE</i> Middle <i>DRURY</i> Last <i>DRURY</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, at unknown		16b. SOCIAL SECURITY NO <i>210-36-6</i>		17 INFORMANT <i>Drury</i>		Address <i>1110</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> , 19 <i>62</i> , to <i>Jan 5</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 4</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Willard F. Smith</i>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <i>1/5/69</i>			
22d PHYSICIAN'S NAME (Type) <i>Willard F. Smith</i>		22e. ADDRESS <i>Shady Side, Maryland</i>							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Landestry Funeral Home</i>		ADDRESS <i>1110</i>		25a REC'D BY REGISTRAR DATE <i>JAN 7 1969</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

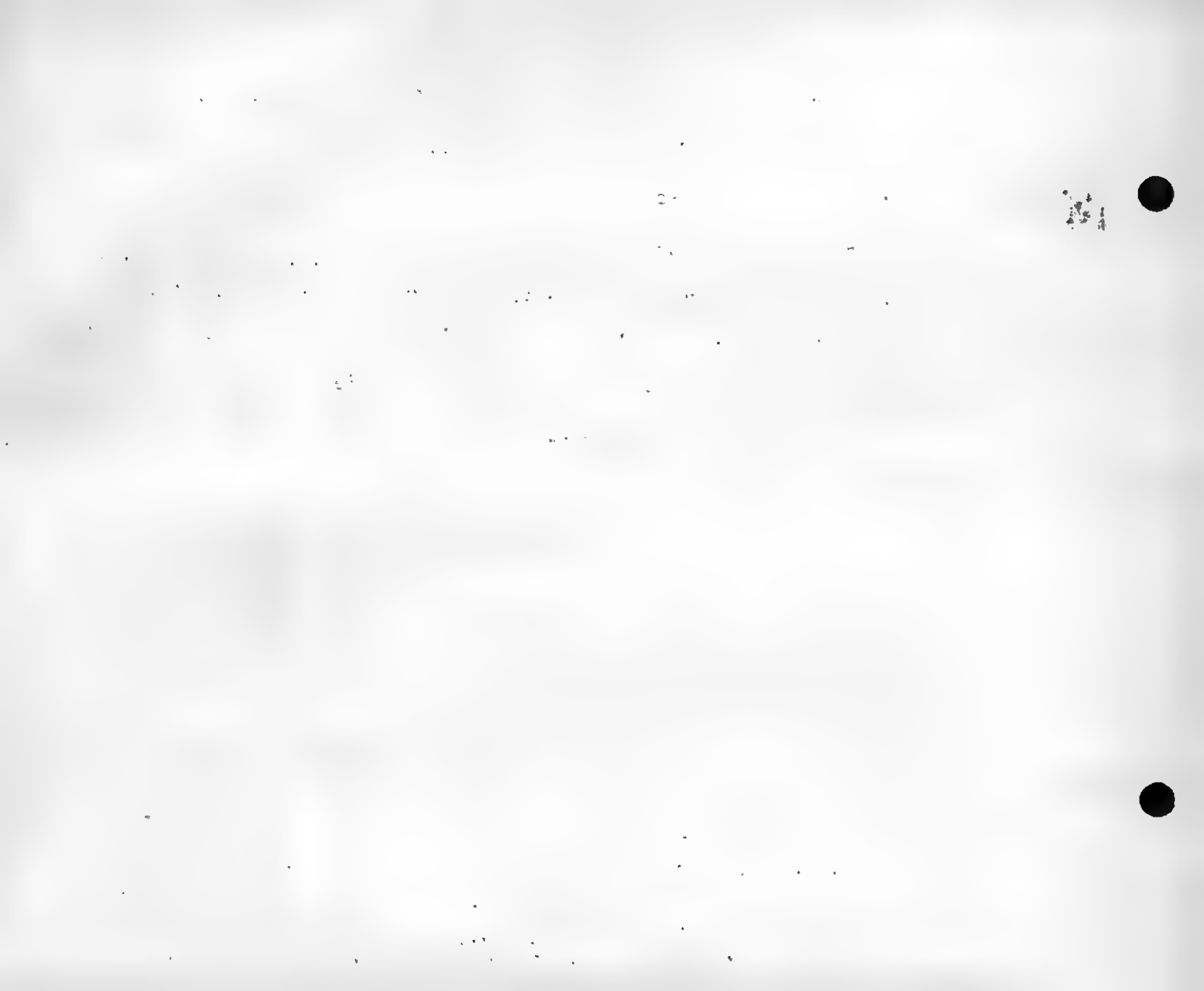
00211

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00210

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>BABY</b>			First <b>BABY</b>			Middle <b>BOY</b>			Last <b>PAJE</b>			2a. DATE OF DEATH January <sup>Month</sup> 21 <sup>Dy</sup> 69 <sup>Year</sup>			2b. HOUR 2045 M		
3. SEX <b>Male</b>			4. RACE <b>Malayan</b>			5. DATE OF BIRTH January 21, 1969			6. AGE (In years lost birthday) YRS.			7. UNDER 1 YEAR MONTHS			8. UNDER 24 HRS HOURS		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>Philippines</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Anne Arundel</b> Md.								
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Nasal Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY <b>N.A.</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Annapolis</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>2 Maryland Avenue</b>					
14. FATHER'S NAME First <b>Patrocinio</b>			Middle <b>M.</b>			Last <b>Paje</b>			15. MOTHER'S MAIDEN NAME First <b>Rizalina</b>			Middle <b>S.</b>			Last <b>Sicon</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>None</b>			17. INFORMANT <b>Patrocinio Paje</b>			Address <b>2 Maryland Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>1111X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr. 50 min.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED January 21, 1969								
22d. PHYSICIAN'S NAME (Type) <b>R. P. KILLINGER, LCDR MC USN</b>			22e. ADDRESS <b>45th ADAPT. Annapolis MD</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>1-23-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>U.S.N. ACADEMY</b>			23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.H. - MD.</b>								
24. FUNERAL DIRECTOR <b>John M. F. Faras</b>			ADDRESS <b>Annapolis, Md.</b>			25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Killian, Judge</b>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
1 DECEASED NAME (Type or print)		First AGATHA		Middle —		Last PALMISANO		2a. DATE OF DEATH Month Day Year JANUARY 31 1969		2b. HOUR 740 P M
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 11-03-92		6 AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) ITALY		7b. CITIZEN OF WHAT COUNTRY? ITALY		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL				
10 CITY OR TOWN OF DEATH GLEN BURNIE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) NORTH ARUNDEL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b KIND OF BUSINESS OR INDUSTRY —				
13a USUAL RESIDENCE (If deceased lived in institution, residence before admission) XX XXXX		13b CITY OR TOWN BALTIMORE		13c STREET AND NUMBER 1207 RAMBLEWOOD ROAD						
14 FATHER'S NAME First Middle Last Angelo Raponese				15. MOTHER'S MAIDEN NAME First Middle Last Antoinette ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes, no, or unknown		16b SOCIAL SECURITY NO 216-28-1720D		17 INFORMANT AN HONY PALMISANO		Address 58 BELMORE RD. LUTHERVILLE				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Colman E. Seitz M.D.</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-31-69
22d. PHYSICIAN'S NAME (Type) Orlando E. Ramos M.D.		22e ADDRESS 1549 Woodbourne Ave Balto 21212								
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE 2/4/1969		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION (City or Town) Baltimore, Maryland		(County) (State)		
24. FUNERAL DIRECTOR Eugenia F. Seitz 5209 York Road Seitz Funeral Home Balto. Md. 21212				25a. REC'D BY REGISTRAR DATE FEB 9 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>				

1. 1

2. 2

3. 3

4. 4

5. 5

6. 6

7. 7

8. 8

9. 9

10. 10

11. 11

12. 12

13. 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
WILLIAM EDWARD PARDOE, Sr.						January 14, 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		May 29, 1913		55 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S.				Anne Arundel Co., Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie			N. Arundel General Hosp. Well Driller						Well Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			A. A.		Clearwater Beach	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		801 Waterview Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William C. Pardoe			Elsie E. Bowen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			213-03-6871		Mrs. Alma Pardoe (same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Blood, Trachea ruptured 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post-irradiation DUE TO, OR AS A CONSEQUENCE OF (c) Ca. of Lung & Lower Trachea									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE			22c. DATE SIGNED						
Frank A. Faraino, M.D.			1-15-1969						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Frank A. Faraino, M.D.			721 Liel. Ark. Hg.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Jan. 17, 1969		Glen Haven Memorial Pk.		Ritchie Hwy., A.A.Co., Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
George J. Gonce, 4001 Ritchie Hgwy., Baltimore			JAN 21 1969			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many others, within 72 hours after death.

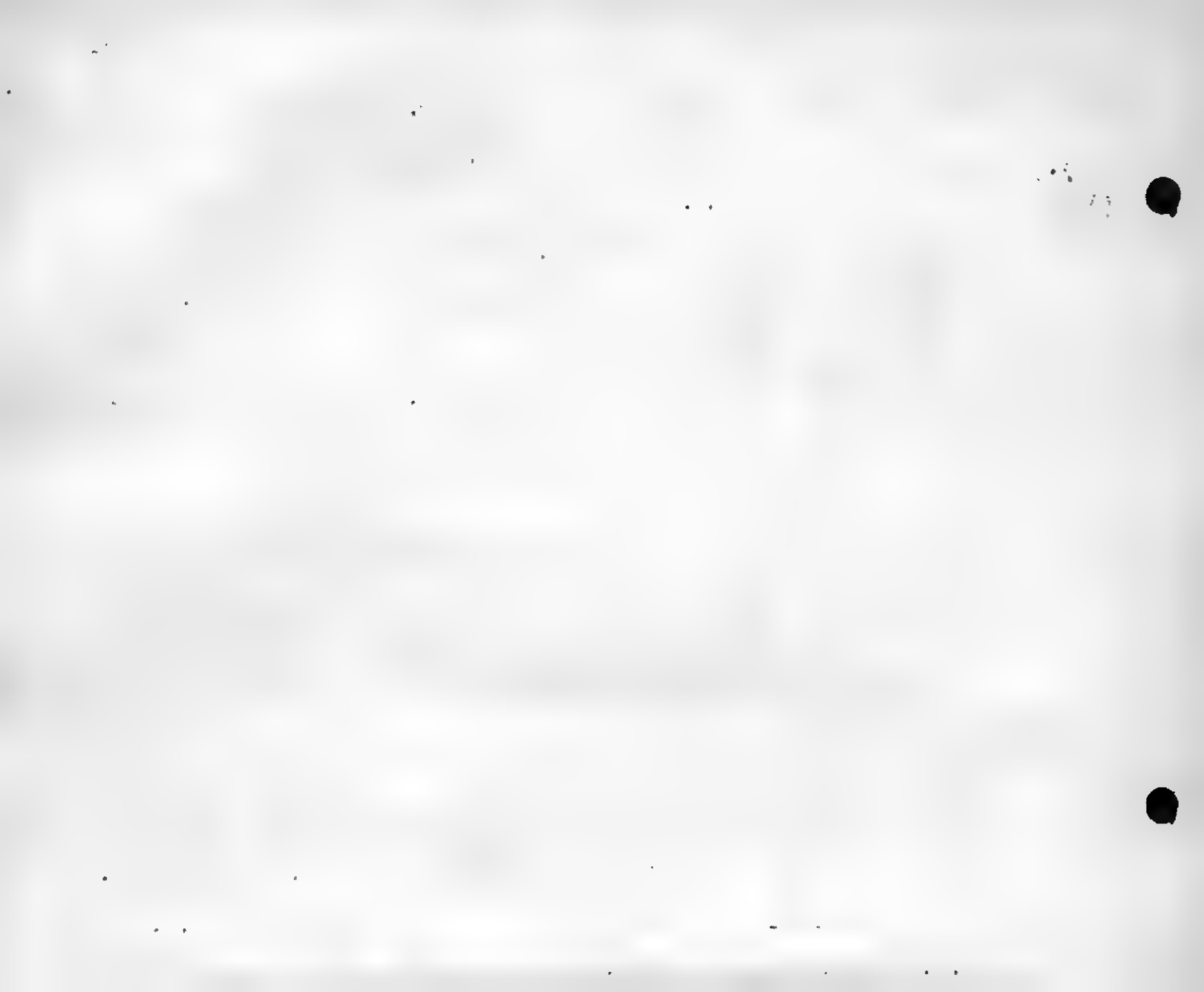
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
James Washington Parker						January 19 1969			6: A M
3 SEX	4 RACE		5 DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	Colored		January 10, 1896			73 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md		U.S.A.				A.A. Co. Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel General			Contractor		*****	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. USUAL CITY L.H. 157		13e. STREET AND NUMBER
Md			A.A. Co				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		304 Bestgate Rd Anna, Md
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
George NMN Parker						Issabelle NMN Addison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			218-14-2190A		Margaret J. Peters 304 Bestgate Rd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular thrombosis</u>									<u>instantly</u>
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Thrombosed atherosclerosis</u>									<u>10 yrs.</u>
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC)		21f. LOCATION					
While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from <u>July</u> , 1968, to <u>June</u> , 1969, that (1) (we) last saw the deceased alive on <u>July 6</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>John Hedeman MD</u>									<u>1/21/69</u>
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
John Hedeman					1407 Forest Drive, Anna, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-23-69		Fowlers		A.A. Co. Md			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
C.E. Hicks, 111 Annapolis, Md							JAN 28 1969		<u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular pages 1 and 2 and file them with the State Dept of Health prior to burial, cremation, or removal, and in accordance with the law.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR	
George			MMN PHELPS, Sr.			January 23 1969			7:05 PM	
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Negro		Feb. 22, 1899		69 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland		U.S.				Anne Arundel Md				
1d. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel Gen. Hospital			Cook				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY (In 1st YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		110 South St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Charles MMN Phelps			Anna MMN Boeze							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
Yes			MMN		214-14-6617 Louise H. Phelps 110 South St. Anne, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									Approx	
IMMEDIATE CAUSE (a) 4123									Yes	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work				Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/10, 1967, to 1/23, 1969, that (I) (we) lost the deceased alive on 1/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
Gerard Church								1/24/69		
22a. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Gerard Church				121 Cathedral St., Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1-27-69		Pine Lawn		Annapolis A.A. Md				
24. FUNERAL DIRECTOR				ADDRESS		25a. RECEIVED BY (Signature)		25b. RECEIVED BY (Signature)		
C.E. Hicks, 111				Annapolis, Md		JAN 28 1969		Judge		



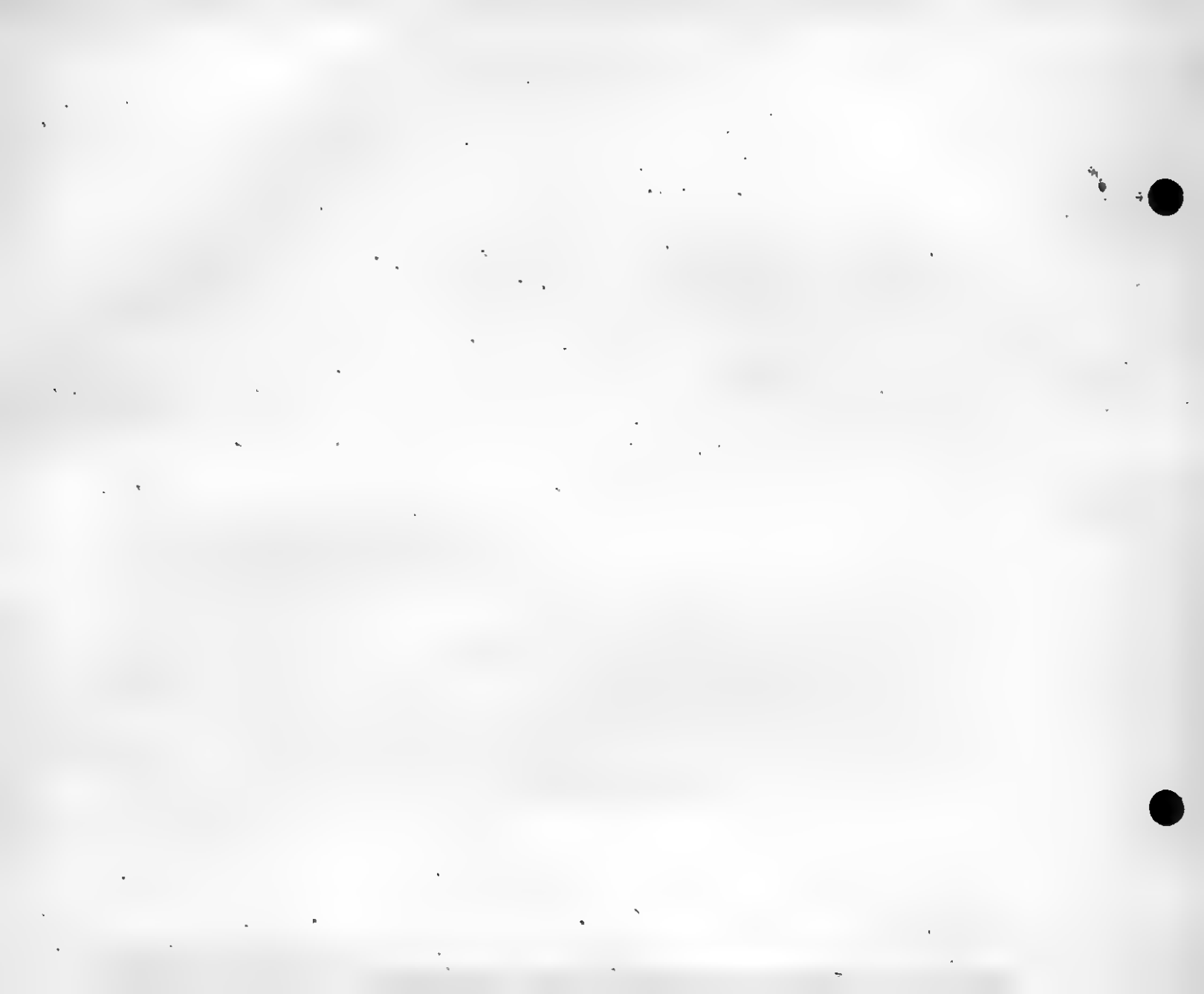
00210

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
JENNIE					Month	Day	Year	254 M	
3. SEX	F	4. RACE	W	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
				7-16-73		9.5 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
NY		USA				A.A. B.		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
MILLERSVILLE		KROGWOOD MANOR N.H.		Housewife		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md		AA		SEVERNA PARK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13 EARLEIGH Hgb Rd	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
George			Werner		Elin			Zimmerman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				Mr Richard Posner		Alone			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage from gastrointestinal tract									
DUE TO, OR AS A CONSEQUENCE OF (b) Thrombocytopenia									1 day
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Leukemia									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from Jan 25, 1969, to Jan 30, 1969, that (I) (we) last saw the deceased alive on Jan 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE				DEGREE	ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED	
R.M. Smith M.D.								Jan 30, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
R.M. SMITH, M.D.				SEVERNA PARK, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		2/3/69		Park View An		Schenectady			N.Y.
24. FUNERAL DIRECTOR		ADDRESS		25a. REGISTRY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert S. Samanow		Severna Park, Md.		FEB 9 1969		R. S. Samanow			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
EARL R. Pumphrey Jr						Month Day Year			Month Day Year		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
M			W			June 23 1901			67 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
Md.			U.S.A.			NEVER MARRIED			A.A. Co		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			Dup - March Avenue			Crane Operator (ret)			Construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Anne Arundel			Glen Burnie			YES NO		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
William Pumphrey			Annie Neident			No			218-16-1292		
17. INFORMANT			18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))			19. DATE OF OPERATION			20. AUTOPSY?		
Mrs. Ethel E. Pumphrey (wife)			Same As #13			1-24-69			YES NO		
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21d. INJURY OCCURRED		
PRIMARY			P.M. 1-24-69			Self inflicted gunshot wound			WHILE AT WORK NOT WHILE AT WORK		
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town			County State		
Scene			Raccoon Mt			Glen Burnie, Md			Raccoon Mt		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
E. Linhart									1-24-69		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			23a. REC'D BY REGISTRAR		
E. Linhart			A.A. Co			A.A. Co			DATE JAN 30 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or town) (County) (State)		
Burial			Jan 28, 1969			Glen Haven Mem. Pk			Glen Burnie, Md		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE		
R. Singleton			Glen Burnie, Md			DATE JAN 30 1969			R. Singleton		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR  
45M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Glenn Irving PUTNAM						January 21 1969			4:15 M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS Min	
Male		White		Dec. 18, 1921		47 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Florida		U.S.				Anne Arundel Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work years (retired))		12b KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel Gen. Hospital		Contractor		BUILDING			
13a U.S. RESIDENCE (Where deceased lived & institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Anne Arundel		Mayo				Mayo Post Office	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
GLENN I PUTNAM SR.						MARY LORISSIA			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17 INFORMANT			Address
YES			WW 2			HELEN M. PUTNAM			# 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Overload of the liver with portal hypertension, Massive obesity</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/20, 1969</u> , to <u>1/21, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/21, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard I. Hochman, M.D.</u>				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1/21/69</u>	
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.				22e. ADDRESS 16 Murray Ave., Annapolis, Md.					
23a BURIAL, CREMATION, REMOVAL, etc.		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1/24/1969		FORT LINCOLN CEM		PRINCE GEO. CO MD.			
24 FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.				ADDRESS		25a REC'D BY REGISTRAR JAN 22 1969		25b REGISTRAR'S SIGNATURE Charles Judge	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00219

00218

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b HOUR
RICHARD OSCAR QUILL									1	4	1969	M
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years at birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR	
Male	White	Aug 3 1915	55 YRS					1			4	M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md			
North Dakota		USA				Anne Arundel						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Annapolis			AA General Hospital									
13a USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE			13b COUNTY			13c CITY OR TOWN			13e STREET AND NUMBER			
Md			AA Co			Round Bay			116 Severn River Rd.			
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last	
Theodore I. Quill						Emma					Rossing	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO (If yes, give year or dates of service)			17. INFORMANT			ADDRESS			
yes			1943-1945 577 14 7202			Doris Quill Round Bay, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4299 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIT ON GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)						22b DATE SIGNED 1/4/69			
EXAMINER'S NAME (Type)			F. Linhardt									
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			1/6/69		Woodfield			Galesville, Md AA Co				
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REG STRAR DATE		25b. REGISTRAR'S SIGNATURE		
Hardesty Funeral Home						Annapolis, Md		JAN 7 1969				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00220

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00219

1. DECEASED-NAME (Type or print)		First JAMES		Middle EDWARD	Lost RANKIN	2a. DATE OF DEATH JAN Month 13 Day 1969 Year		2b. HOUR 1:45 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan 13, 1969		6. AGE (In years last birthday) — YRS		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Ft Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route #1, Box 200	
14. FATHER'S NAME		First David		Middle	Lost Rankin	15. MOTHER'S MAIDEN NAME		First Barbara	
								Middle Faulkner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give year or dates of service) N/A		16b. SOCIAL SECURITY NO None		17. INFORMANT David Rankin, Route #1, Box 200, Laurel, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY DEPRESSION</u> <u>776.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Hrs 8 Min	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from <u>13 Jan</u> , 19 <u>69</u> , to <u>13 Jan</u> , 19 <u>69</u> , that (1) (we) lost the deceased alive on <u>13 Jan</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) view the body after death.									
22b. SIGNATURE <u>William J. Weston MD</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 13 Jan 1969		
22d. PHYSICIAN'S NAME (Type) WILLIAM L. WESTON, CPT, MC,					22e. ADDRESS U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN. 16, 1969		23c. NAME OF CEMETERY OR CREMATORY EDGEWOOD CEM.		23d. LOCATION (City or Town) (County) (State) LOWELL N.C.			
24. FUNERAL DIRECTOR ASWARD		ADDRESS COUNTY F.H. ELLICOTT CITY			25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

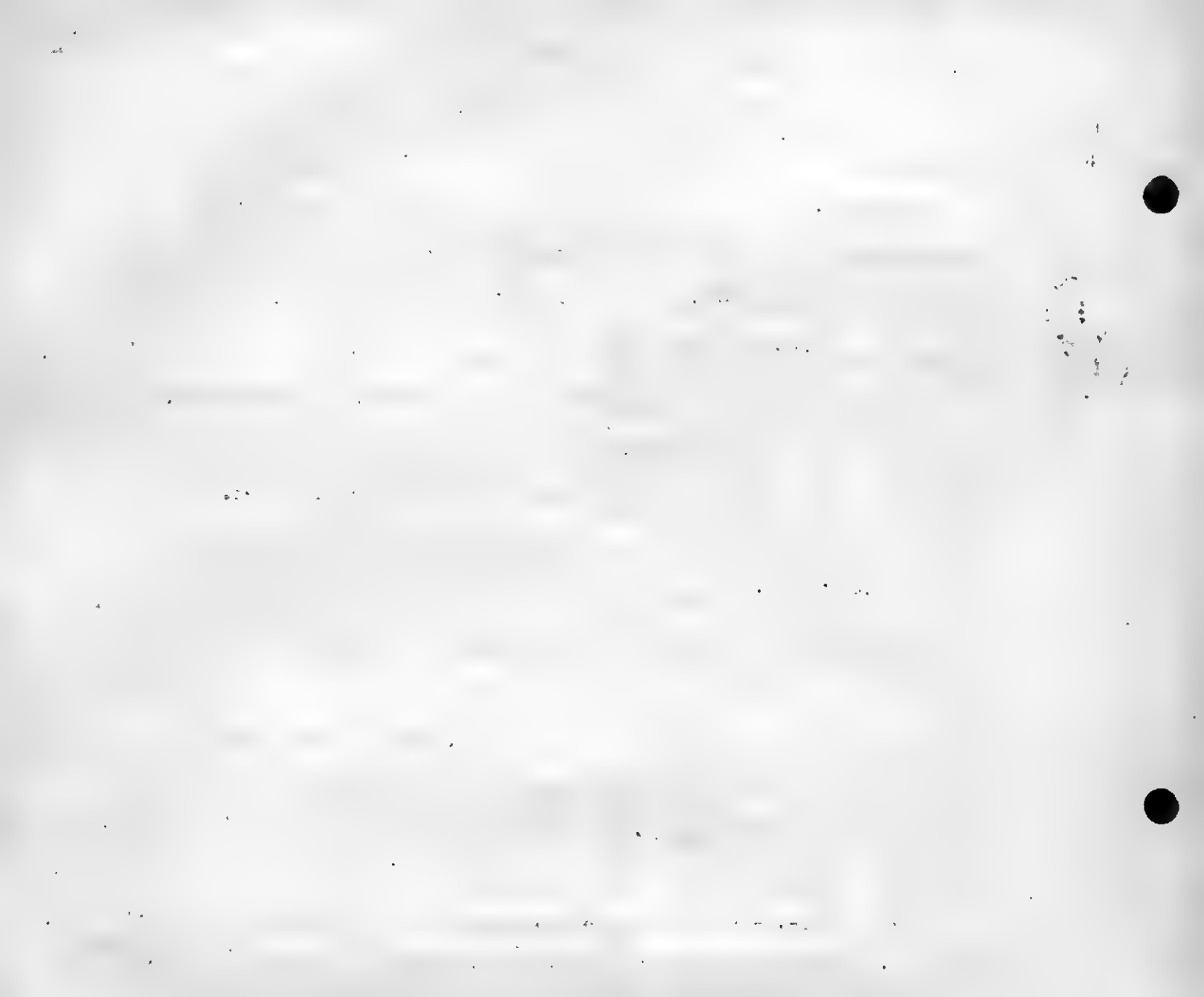
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH
William Joseph REID									Month Day Year Jan. 6, 1969
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		2b. HOUR P.
Male		White		Jan. 31, 1999			69 YRS		5:18 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Anne Arundel County Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			AA General			Postal Clerk		Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md			AA Co		Mayo		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1603 Cliff Drive
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME
Thomas Reid									Sarah Tacey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
Yes			1918-19		216 44 7675		Wm. R. Reid Mayo, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary myocardial infarction</u>									chest
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral artery insufficiency + sclerosis</u>									5 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town	County
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (1) this hospital attended the deceased from <u>Jan</u> , 1965, to <u>Jan</u> , 1969, that (1)(we) last saw the deceased alive on <u>Dec. 29</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1)(we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>John L. Hedeman</u>								1/9/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
John L. Hedeman, M.D.		1407 Forest Dr., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Jan 10, 1969		Mt. Olivet		Wash, DC			
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hardesty Funeral Home		Annapolis, Md.				JAN 13 1969		<u>William S. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

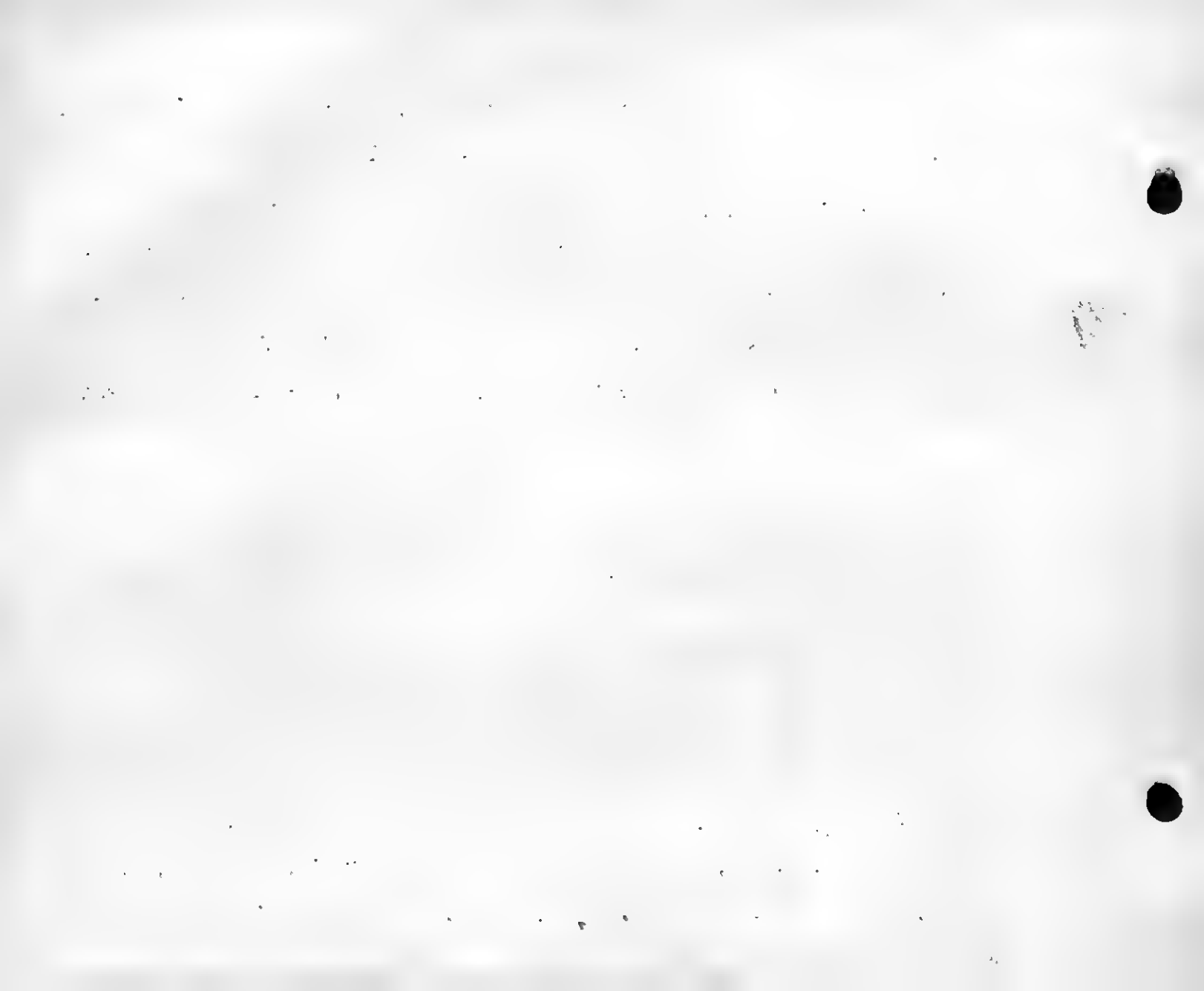
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Thelma					Reimsnyder	1 6 68			6:30a M
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		5/1/98		70 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
unknown Md.		USA				Anne Arundel Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Crownsville			Crownsville State Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Res. date before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel			Hanover		Hanover Road Box 1-B	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
unknown			Grimm			unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address			
No unknown			unknown			Hospital Records, Crownsville State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Aspirin Pneumonitis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Arteriosclerotic cardio vascular disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Hyperthyroidism</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/19/68</u> , 19 <u>68</u> , to <u>1/6/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/6/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles R. Venter, M.D.</u>					DEGREE		22c. DATE SIGNED <u>1/7/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Charles R. Venter, M.D.</u>					22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-17-1969		Zion Cemetery		Baltimore Howard Md.			
24. FUNERAL DIRECTOR ADDRESS <u>21229</u>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Howard H. Hubbard 4107 Wilkens Ave. Baltimore					JAN 21 1969		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First JOHN			Middle ERNEST		Last REINBURG Jr.		2a. DATE OF DEATH Month January		Day 16		Year 1969		2b. HOUR 7:45A <sup>M</sup>	
3 SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH 30 August 1893			6. AGE (In years lost birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE ARUNDEL			Md					
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NAVY - Capt. Ret.			12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY ANNE ARUNDEL			13c. CITY OR TOWN ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 207 NORWOOD ROAD					
14. FATHER'S NAME First JOHN			Middle ERNEST			Last REINBURG			15. MOTHER'S MAIDEN NAME First LOUMINOR			Middle NEBANE			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES			16b. SOCIAL SECURITY NO 1916-1955			16c. SOCIAL SECURITY NO 219386413			17. INFORMANT MRS. FRANCES REINBURG			Address 207 NORWOOD ROAD					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 240X IMMEDIATE CAUSE (a) MULTIPLE SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
CHRONIC PYELONEPHRITIS																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Michael F. Fornes MD			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type) M.F. FORNES, LCDR MC USN			22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD. 21402														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 1-17-69			23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.			23d. LOCATION (City or Town) (County) (State) Arlington, Va.								
24. FUNERAL DIRECTOR John M. Taylor & Son Annapolis, Md.			25a. APPROVED BY REGISTRAR JAN 20 1969			25b. REGISTRAR'S SIGNATURE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

54  
02  
1

2

VR 450  
30M REV. 5-68

00223										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00223														
CERTIFICATE OF DEATH																																		
1 DECEASED-NAME (Type or print)					First Carrie					Middle L.					Last Richardson					2a DATE OF DEATH					1 Month 22 Day 69 Year					2b HOUR 11:50 P				
3 SEX Female					4 RACE White					5. DATE OF BIRTH 9-8-87					6 AGE (In years last birthday) 87					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					IF UNDER 24 HRS									
7a BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH A.A.Co. Md																			
10 CITY OR TOWN OF DEATH Glen Burnie					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housework					12b KIND OF BUSINESS OR INDUSTRY Own Home																			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland					13b COUNTY A.A.Co.					13c CITY OR TOWN Glen Burnie					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER 413 3rd. Ave. S.W.														
14. FATHER'S NAME First Ludwig					Middle T.					Last Pveritz					15 MOTHER'S MAIDEN NAME First Sophia					Middle Hammerstrom					Last Elvaton									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No					(If yes give war or dates of service) None					16b SOCIAL SECURITY NO. 213-05-8313-0					17. INFORMANT Mrs. Norman Richardson (grandson) Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF AS HD - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia, CHF, Fracture hip.																																		
19a DATE OF OPERATION 12/24/68					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture hip										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 12 22 1968					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) Fell at home																								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work					21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) Office BUILDING, ETC. Home					21f LOCATION Street or R.F.D. No. 413-3rd on SW					City or Town Glen Burnie					County AA					State Md									
22a. I certify that (I) (this hospital) attended the deceased from 12/23/68, 19__, to 1/22/69, 19__, that (I) (we) last saw the deceased alive on 1/22/69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b SIGNATURE Jorge B. Ramirez M.D.										22c DATE SIGNED 1/23/69					22d PHYSICIAN'S NAME (Type) Jorge B. Ramirez M.D.										22e ADDRESS 325 Hospital Dr or Glen Burnie 21061 3427 Annapolis Rd Balt 21201									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 1/25/69					23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery					23d LOCATION (City or Town) Baltimore, Maryland										(County) (State)									
24 FUNERAL DIRECTOR E.B. Flomeny										ADDRESS Singleton Funeral Home Glen Burnie, Md.					25a. REC'D BY REGISTRAR JAN 27 1969					25b REGISTRAR'S SIGNATURE Charles Judge														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>KENNETH CLEND</i>		First	Middle	Last	2a. DATE OF DEATH Month <i>19</i> Day <i>19</i> Year <i>1969</i>		2b. HOUR M		
3 SEX <i>MALE</i>	4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>MAY 11, 1893</i>		6 AGE (in years last birthday) <i>73</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>SPRINGVILLE UTAH</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>ANNE ARUNDEL</i> Md.			
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>ANNAP. CONVAL. HOME</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>MUSIC INSTRUCTOR</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>PUBLIC SCHOOLS</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>A.A.G. ANNAPOLIS</i>		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET AND NUMBER <i>1035 NORMAN DR.</i>		14. FATHER'S NAME First <i>AARON</i> Middle <i>W.</i> Last <i>ROYLANCE</i>		15. MOTHER'S MAIDEN NAME First <i>CHARLOTTE</i> Middle <i>E.</i> Last <i>BERRY</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>—</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>MRS. UNA MARIE ROYLANCE #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCUM</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>—</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Parkinson's disease, Fracture @ Glenoid Scapula</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>1</i> , 19 <i>68</i> , to <i>11/19</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>11/19</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. BIERN</i>		22c. DATE <i>11/21/1969</i>			22d. PHYSICIAN'S NAME (Type) <i>R. BIERN</i>		22e. ADDRESS <i>121 CATHARAL ST ANNAPOLIS MD</i>		22f. DATE SIGNED <i>11/19/69</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>11/21/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HILLCREST Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>ANNAPOLIS AAG MD.</i>			
24. FUNERAL DIRECTOR <i>John M. Fayth Sons</i>		24b. ADDRESS <i>Annapolis, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>JAN 26 1969</i>		25b. REGISTRAR'S SIGNATURE <i>—</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>William</i>			First <i>H</i> Middle <i>Ryan</i> Last <i>Ryan</i>			2a DATE OF DEATH Month <i>1</i> Day <i>25</i> Year <i>69</i>			2b HOUR <i>3:00 PM</i>
3. SEX <i>m</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>JAN. 15, 1885</i>		6 AGE (In years lost birthday) <i>84</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS HOURS <i></i> MIN <i></i>
7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>A.A. CO.</i>			
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>ANNAPOLIS NURSING HOME</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>MACHINIST</i>		12b KIND OF BUSINESS OR INDUSTRY <i>U.S. N. YARD</i>			
13a USUAL RESIDENCE (Where deceased admission) STATE <i>MD</i>		13b. COUNTY <i>AA CO.</i>		13c CITY OR TOWN <i>Shoreham Beach</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>1427 YANKEE DR</i>	
14 FATHER'S NAME <i>FRANK CASPER</i>			First <i></i> Middle <i></i> Last <i>RYAN</i>			15. MOTHER'S MAIDEN NAME <i>mary Dooley</i>			First <i></i> Middle <i></i> Last <i></i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO <i></i>			17 INFORMANT <i>CLARA M. RYAN</i>			Address <i># 73</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral anoxia</i> Immediate Cause <i>1991</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Circulatory failure, within approx one hour</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Squamous Cell Carcinoma, origin unknown. One year</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i></i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>William H. Choate, MD</i>				DEGREE <i></i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>25 Jan 1969</i>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL, ETC.		23b. DATE <i>1/28/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HILLCREST CEM</i>		23d. LOCATION (City or Town) (County) (State) <i>ANNAPOLIS MD</i>			
24. FUNERAL DIRECTOR <i>John M. Layla &amp; Sons Annapolis, Md.</i>				ADDRESS <i></i>		25a. REC'D BY REGISTRAR DATE <i>JAN 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

66  
7



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen on Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
August Gaspero Scardina					EST. MATED		1-1		1969	A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
M	W	Apr. 1, 1896		72 YRS	MONTHS DAYS		HOURS MIN.		Month 1 Day 1 Year 69	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH		
Sicily		U.S.A.		WIDOWED		DIVORCED		Anne Arundel Co		MD
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie		D.A. North Brunel				Ret. Tavern Operator				
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS		13e STREET AND NUMBER		
Md		Ad-Co.		Glen Burnie		YES NO		Route 2 Box 180		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
Cologero Scardina					Josephine Serio					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
Yes		WW II		Mr. George Scardina		Route 2 Box 180 G.B.				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic C.V.D.</u>										<u>1 hour</u>
4124 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/>		HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
<input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>E. Linhardt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED		
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				1-1-69		
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				A. A. Co.		
ADDRESS (Street, city, town or county)										
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		1/4/69		Glen Haven		Glen Burnie, Md.				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
McCully F.H. 237 Patapsco Ave				DATE JAN 6 1969		J. Charles Judge				

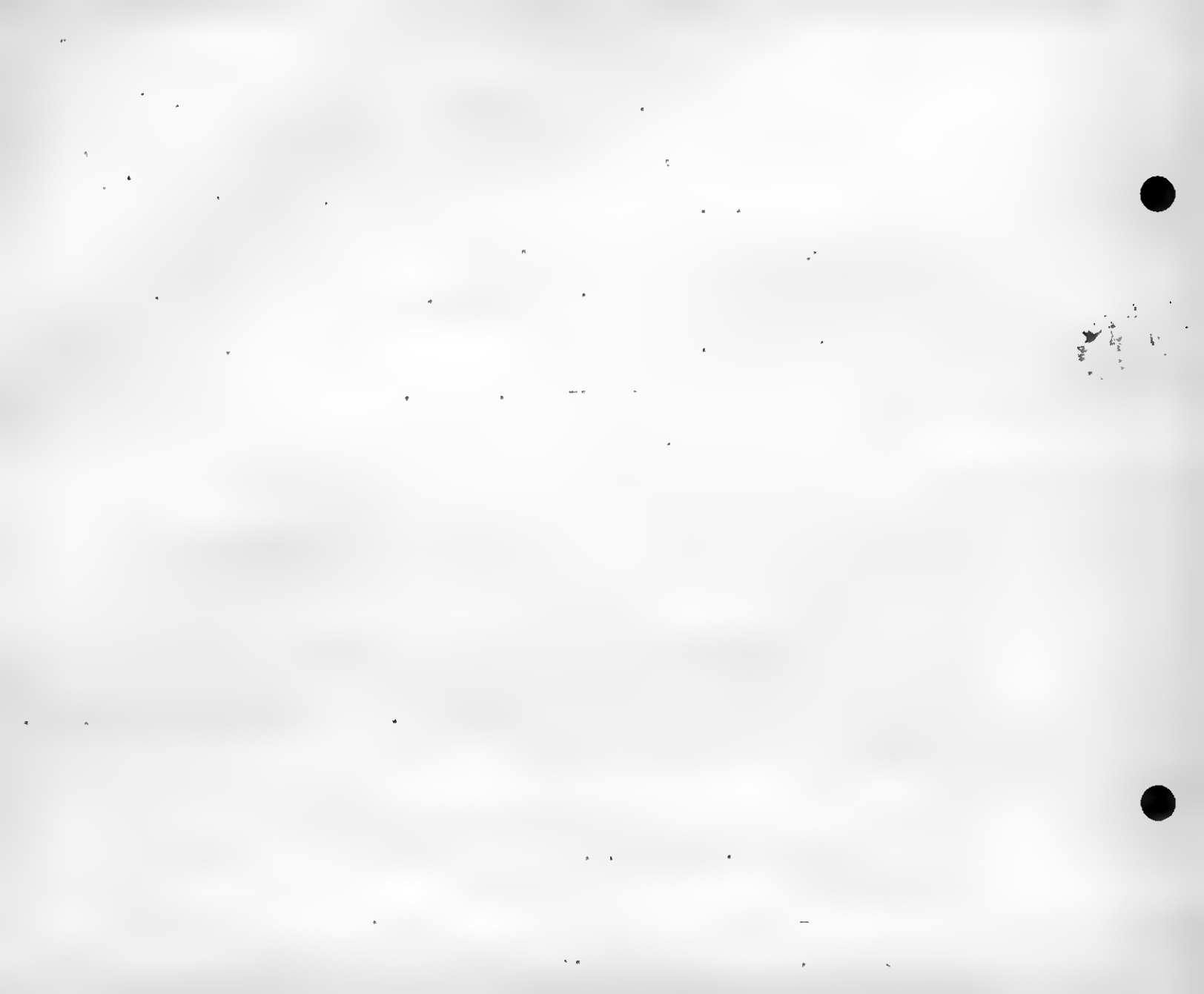


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Karl C. Schoene						Month Day Year		3:05 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
male	white	March 17, 1954	14 YRS	MONTHS DAYS	HOURS MIN.	Month Day Year		3:05 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S.				Anne Arundel Baltimore County		Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Brooklyn Park			188 9 Ballman Ct.,			Schoolboy			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Anne Arundel Co.			Brooklyn Pk.		108 E 11 <sup>th</sup> Ave.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Karl O. Schoene			Alice V. Shewbridge						
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			p-----			Mr. Karl O. Schoene - same			
18 CAUSE OF DEATH (Enter on any one cause per line for (a) (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>shotgun wound of neck</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				3:05 P.M. 1, 17 1969		gun discharged in contact with neck			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
		building		9 Ballman Ct.		Baltimore Co.,		Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)		22b. DATE SIGNED			
						Jan 18, 1969			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		1-21-1969		Baltimore National Cem.		Baltimore, Maryland			
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
George J. Gonce, 4001 Ritchie Hwy., Baltimore				DATE JAN 23 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

022.1										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00228									
1 DECEASED NAME (Type or print) <i>Catherine</i>										First Middle Last <i>(Shedlock) Sedlak</i>										2a. DATE OF DEATH				2b. HOUR					
																				Month Day Year <i>1 30 69</i>				M <i>6 30</i>					
3. SEX <i>F</i>										4. RACE <i>W</i>										5. DATE OF BIRTH <i>10/28/1918</i>				6. AGE (In years lost birthday) <i>70</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>										7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Anne Arundel</i>				Md	
10. CITY OR TOWN OF DEATH <i>Ben Burnie</i>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>North Arundel Convalescent Center</i>										12a. USUAL OCCUPATION (Kind of work done during most of work ng. life, even if retired) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>										13b. COUNTY <i>Anne Arundel</i>										13c. CITY OR TOWN <i>Severna Park</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>49 St. Andrews Rd.</i>			
14. FATHER'S NAME First Middle Last <i>William ---- Zayo</i>										15. MOTHER'S MAIDEN NAME First Middle Last <i>Theresa ---- Buddie</i>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. <i>198-20-4238</i>										17. INFORMANT Address <i>Mrs. Catherine Gullifer, 49 St. Andrews Rd.</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>20 yr</i>																													
(b) <i>Diabetes Mellitus</i>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>John I. Stern</i>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										23b. DATE <i>2-3-1969</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Ritchie Hgwy., A.A.Co., Md.</i>					
24. FUNERAL DIRECTOR <i>George J. Gonce, 4001 Ritchie Hgwy., Baltimore</i>										25a. REC'D BY REGISTRAR <i>FEB 5 1969</i>										25b. REGISTRAR'S SIGNATURE <i>Thomas J. Judge</i>									



Item 1 Film 2409 2/5/69 kk

## CERTIFICATE OF DEATH

00229

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn, Baltimore, Md. 21225</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4209 3rd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Florence</b> Last <b>Sieg</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>1969</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1913</b>
9. AGE (In years last birthday) <b>55</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (Country & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George C. Ernest</b>		14. MOTHER'S MAIDEN NAME <b>Olia Linton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Audrey E. Schilpp 601 Hopkins St.</b>		Address <b>21225</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>378x</b> IMMEDIATE CAUSE (a) <b>Rheumatic heart disease and carcinoma of lung with metastases</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE <b>Edward F. Wilson</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		22d. ADDRESS <b>700 Fleet St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/1/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>McCurdy F. H. 237 Patapsco Ave. 21225</b>		25a. REC'D BY REGISTRAR <b>JAN 31 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Alvin A. Jander</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

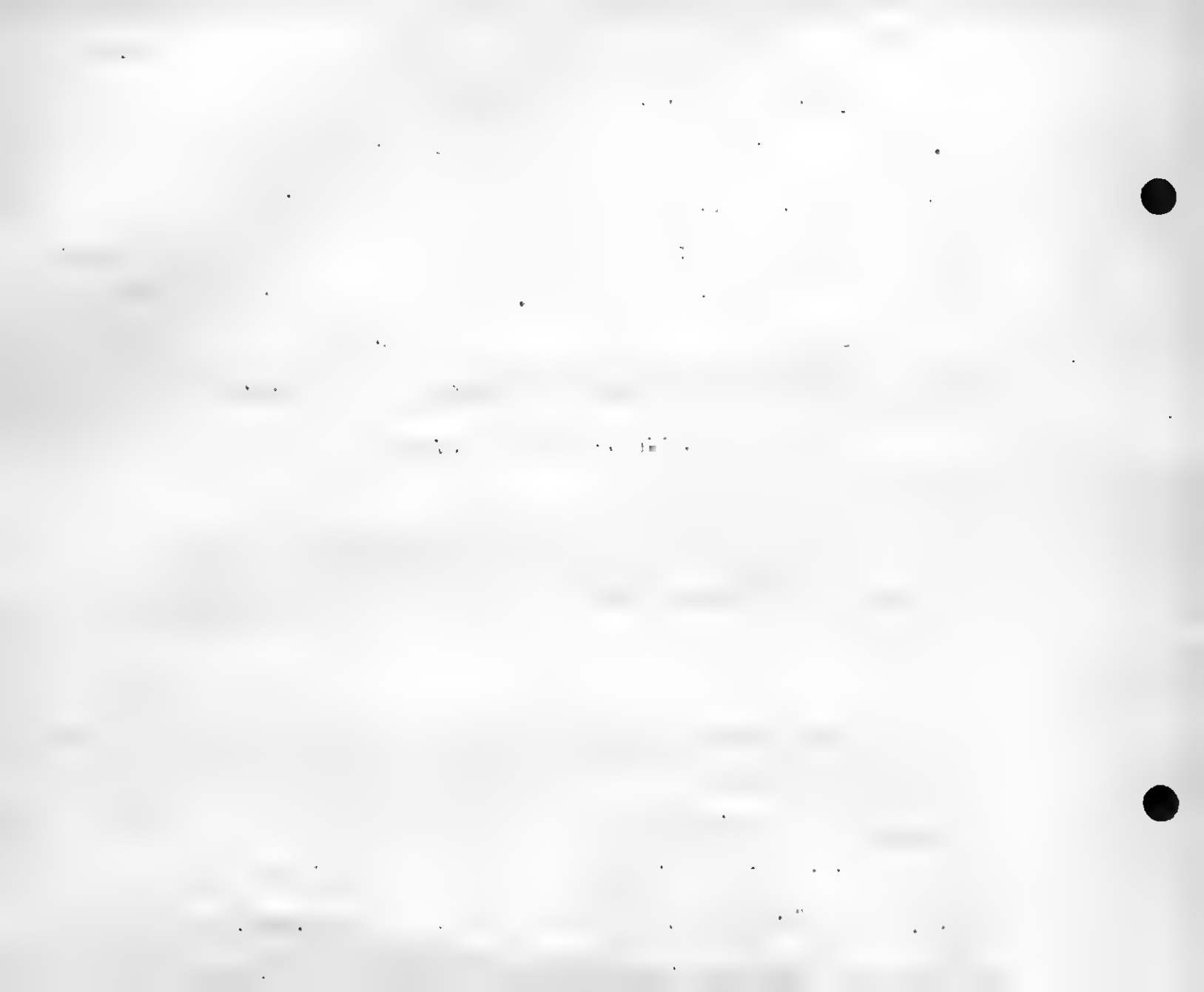
355-1185



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
EFFIE				NORWOOD	SMITH	January 23 1969		9:40 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		Caucasian		9 March 1897		71 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Solomon Island, Md.		U.S.				Anne Arundel Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Naval Hospital			Housewife		NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis				134 Market Street	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Gus					Evans	Molley				?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address		
NO			220-16-9014			HOWARD S. SMITH		# 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC PULMONARY EMPHYSEMA</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
M.F. Fornes										1-23-69
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
M.F. FORNES, LCDR MC USN			U.S.C.A. Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial			1-28-69		Huntington Nat'l		Annapolis			va.
24. FUNERAL DIRECTOR			ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John M. Geyser			Annapolis, Md.		JAN 27 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1-69  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <b>EVELYN M. SMITH</b>					2a. DATE OF DEATH Month <b>1</b> Day <b>12</b> Year <b>69</b>			2b. HOUR <b>11:50</b> P.M.		
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>4-11-07</b>		6. AGE (In years last birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>A.A. Co.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NORTH ARUNDEL Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>photographer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MD.</b>			13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>SEVERNA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>613 Cypress LAINE</b>	
14. FATHER'S NAME First <b>JAMES H</b> Middle <b>NORTON</b> Last <b>NORTON</b>			15. MOTHER'S MAIDEN NAME First <b>DAISY</b> Middle <b>M.</b> Last <b>HEATH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or at unknown (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Name <b>BURTON L. SMITH</b> Address <b>ABOVE</b>					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac decompensation (pulmonary edema)</b> <b>5 days</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aortic stenosis</b> <b>Many years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatic fever, probable</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Metastases to lungs and liver from carcinoma of colon.</b>										
19a. DATE OF OPERATION <b>Dec. 23, '65</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of sigmoid colon</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 3</b> , 19 <b>65</b> , to <b>Dec. 4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec. 4</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John Tilden Howard, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Jan. 15 '69</b>		
22d. PHYSICIAN'S NAME (Type) <b>John Tilden Howard, M. D.</b>				22e. ADDRESS <b>12 E. Eager St., Baltimore, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-16-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOW RIDGE CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>DORSEY Hw. Md</b>				
24. FUNERAL DIRECTOR <b>Phat S. Berraneco, Severna Park, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) <b>John</b>			First <b>C</b> Middle <b>Smith</b> Last			2a. DATE OF DEATH <b>Jan.</b> Month <b>8</b> Day <b>69</b> Year		2b. HOUR <b>10:24</b> P.M.	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10-3-97</b>		6. AGE (In years last birthday) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Anne Arundel</b> Md.			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>North Arundel</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>truck driver-retired</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b> COUNTY <b>Howard</b> CITY OR TOWN <b>Dorsey</b>		13b COUNTY <b>XXXXXXX</b>		13c CITY OR TOWN <b>XXXXXXX</b>		13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>Box 109 Rt. 4</b>	
14 FATHER'S NAME <b>Ralph Smith</b>			First <b>Smith</b> Middle Last			15 MOTHER'S MAIDEN NAME <b>Ida Ness</b> First <b>Ness</b> Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes, give year or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO <b>215.14.5338</b>		17 INFORMANT <b>Lydia Smith</b> Address <b>Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary arteriosclerosis</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 <b>12/29/68</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/8/69</b> to <b>1/8/69</b> , that (I) (we) last saw the deceased alive on <b>1/8/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Max C Frank</b>		DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>1/9/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>MAX C FRANK</b>		22e. ADDRESS <b>425 SE Ritchie Hwy Glen Burnie</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 13, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Dorsey Maryland</b>			
24. FUNERAL DIRECTOR <b>J.T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Road</b>		25a. REC'D BY REGISTRAR <b>JAN 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death  
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR 4-17-68  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
William R. Smuck						Month Day Year Jan. 21, 1969			M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Male		White		July 14, 1946			22 YRS.		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.						Anne Arundel, Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Balto. Suburban			8050 Ritchie Hwy.			Contractor			self-employed		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Anne Arundel			Balto. Sub.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				17. INFORMANT	
Harry A. Smuck			Thelma Prodeohl			No				Mrs. Anita Marocco Same	
16a. SOCIAL SECURITY NO			17. INFORMANT			Address					
214-46-2368			Mrs. Anita Marocco			Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									1 day		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									32 mos.		
(b) <u>Acute leukemia, myeloblastic</u>											
(c) <u>leukemia</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									0		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
						May 1966 to Jan. 21, 1969					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1966</u> to <u>Jan. 21, 1969</u> , that (I) (we) lost the deceased alive on <u>Jan. 21, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)					
Wm Carl Ebeling			1-21-1969			William Carl Ebeling, M.D.					
22e. ADDRESS			22f. ADDRESS			701 St. Paul St., Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jan. 24, 1969			Holy Cross Cemetery			Ritchie Hwy., A.A.Co., Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE		
George J. Gonce, 1001 Ritchie H gwy., Baltimore			JAN 29 1969			Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)		First JENNIFER		Middle		Last SPANGLER		2a DATE OF DEATH JAN Month 14 Day 1969 Year		2b HOUR 9:23 M		
3 SEX Female		4 RACE White		5. DATE OF BIRTH Jan 13, 1969			6 AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Anne Arundel Md					
10 CITY OR TOWN OF DEATH Ft Geo G. Meade			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b KIND OF BUSINESS OR INDUSTRY N/A			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 20 Cort Pleasant, Apt C-4			
14 FATHER'S NAME First Middle Last David Livingston Spangler				15 MOTHER'S MAIDEN NAME First Middle Last Mary Ann Jean Gelbutts								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b SOCIAL SECURITY NO. N/A		17 INFORMANT Address David L. Spangler, 20 Court Pleasant, Apt C-4							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7762 RESPIRATORY & CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Hour		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that I (this hospital) attended the deceased from 13 Jan, 19 69, to 14 Jan, 19 69, that I (we) last saw the deceased alive on 14 Jan, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Michael A. Lee M.D.				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 14 January 69				
22d. PHYSICIAN'S NAME (Type) MICHAEL A. LEE, CPT, MC				22e ADDRESS U.S. KIMBROUGH ARMY HOSP, FT. MEADE, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN 16 69		23c. NAME OF CEMETERY OR CREMATORY ST. CASHMIR				23d. LOCATION (City or Town) (County) (State) POTTSVILLE, PENNA				
24 FUNERAL DIRECTOR Helen W. Lee				ADDRESS 21043 FLEXINGTON CITY, MD.				25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE John H. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

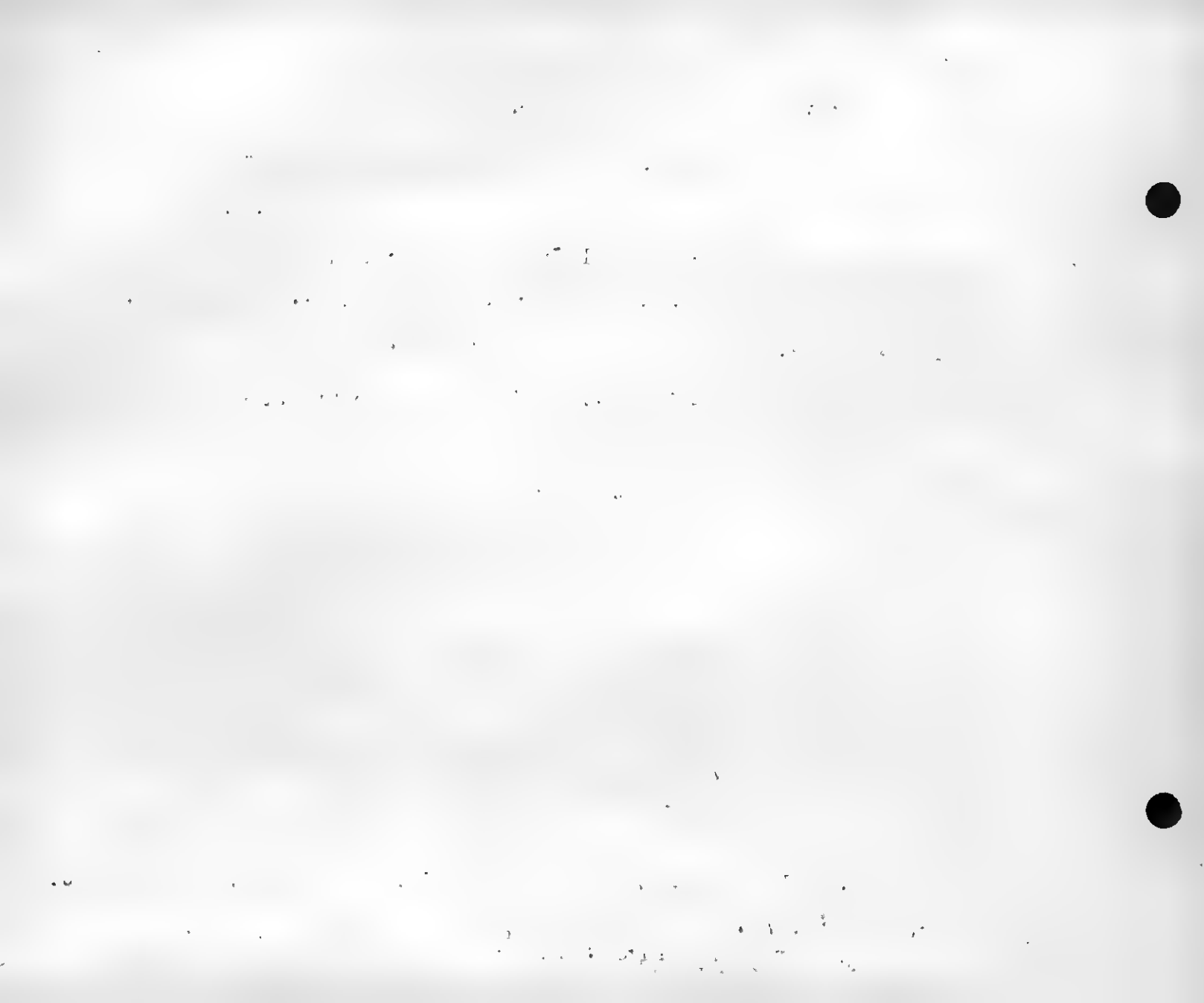
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Ruth Frances SPRIGGS						January 19 1969		3:10 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. UNDER 1 YEAR	
Female		White		April 4, 1906		62 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Maryland		U.S.				Anne Arundel		Annapolis	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY	
Anne Arundel Gen. Hospital		hairdresser		own business		Maryland		Anne Arundel	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Weems Creek		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		--		Harry Spriggs		Annanda Louise Weeden	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))	
no		214-05-1431		John W. Smith - 614 Ridgley Ave. Weems Creek		Annapolis, Md.		PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 4369 DUE TO, OR AS A CONSEQUENCE OF (b) <u>3 DAYS</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CEREBRAL VASCULAR ACCIDENT (1950)</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21e. LOCATION Street or R.F.D. No City or Town County State	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. PLACE OF INJURY		21e. LOCATION	
22a. I certify that (1) (this hospital) attended the deceased from <u>June 1963</u> to <u>July 1969</u> , that (2) (we) last saw the deceased alive on <u>19 Jan 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (d) (d) (d) view the body after death		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
		Edward S. Beck		4/29/69		Edward S. Beck, M.D.		73 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR	
Burial		1/21/69		Cedar Bluff Cemetery		Annapolis A.A. Md.		E. Hopping	
25a. REC'D		25b. REGISTRATION		25c. REGISTRATION		25d. REGISTRATION		25e. REGISTRATION	
JAN 23 1969		JAN 23 1969		JAN 23 1969		JAN 23 1969		JAN 23 1969	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Mazie												
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Mazie			A		Staylor				Month 1 Day 26 Year 69		M	
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
F			Caucasian			XXXX 9 / 15 / 83			85 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			USA						A. A.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Pasadena			4104 Arundel Ct			Seamstress			Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md			A. A.			Pasadena			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4104 Arundel Ct	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Moses O. Atkinson			Henrietta Mund									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address			
No			213-01-0931			Mrs Mazie Precht Same as 13e						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia												
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/17/64, 19__, to 8/20/68, 19__, that (I) (we) last saw the deceased alive on 8/20/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			
C. Earl Hill			1/27/69			C. Earl Hill, M. D.			395 Ft. Smallwood Rd., Pasadena, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			1/30/69			London Park			Catonsville, Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Wm. Cook-Brooks			6212 Balt. Nat. Pike West Inc			JAN 31 1969			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00235

CERTIFICATE OF DEATH

00237

1. DECEASED-NAME (Type or print) <b>Wayne B. Steinman</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>28</b> Year <b>69</b>			2b. HOUR <b>8:20 A</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>September 7, 1925</b>		6. AGE (In years last birthday) <b>43</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.	
10. CITY OR TOWN OF DEATH <b>Glen Burnie, Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bowl America</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY, IN TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>19 Melville Road</b>		14. FATHER'S NAME First <b>Jesse W.</b> Middle <b>Steinman</b> Last <b>Steinman</b>		15. MOTHER'S MAIDEN NAME First <b>Gladys M.</b> Middle <b>Norris</b> Last <b>Norris</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO <b>365-22-4755</b>		17. INFORMANT <b>Rita Steinman, 19 Melville Road, Pasadena</b>		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>10-28</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 Mos.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>6-16-69</b> , 19 <b>69</b> , to <b>1-27-69</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1-27-69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C. B. MacDonald</b>				22c. DATE SIGNED <b>1-28-69</b>		22d. PHYSICIAN'S NAME (Type) <b>C. B. MacDonald</b>	
22e. ADDRESS <b>325 Hospital Drive, Glen Burnie</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan 31, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Maryland</b>	
24. FUNERAL DIRECTOR <b>R. L. Singleton</b>		25a. REC'D BY REGISTRAR <b>JAN 30 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items #5, 6, 7a, b & 8 <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
1 DECEASED NAME (Type or Print) <b>CHARLES STUTSON</b>						2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		2b HOUR <input type="checkbox"/>		2c DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>	
3 SEX <b>male</b>		4 RACE <b>negro</b>		5 DATE OF BIRTH <b>Unknown</b>		6 AGE (In years and birthday) <b>60 &amp; 70 RS</b>		7a BIRTHPLACE (State or foreign country) <b>Unknown</b>		7b CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Anne Arundel</b>		10 CITY OR TOWN OF DEATH <b>Severn</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RR 2, Box 220, Jones Road</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Unknown</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Anne Arundel</b>		13c CITY OR TOWN <b>Severn</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>RR 2, Box 220, Jones Road</b>		12b KIND OF BUSINESS OR INDUSTRY	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16b SOCIAL SECURITY NO				17 INFORMANT				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. <b>19</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Werner U. Spitz</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <b>1/6/69</b>			
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ADDRESS (Street, city, town, or county)				23a BURIAL (CREMATION REMOVAL) (Specify) <b>2-20-69</b>				23b DATE			
23c NAME OF CEMETERY OR CREMATORY <b>U. Md. School Baltimore, Md.</b>				23d LOCATION (City or Town) (County) (State)				24. FUNERAL DIRECTOR			
ADDRESS				25a REC'D BY REGISTRAR DATE <b>FEB 24 1969</b>				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Anna Ruth Tapp						Jan. 7 1969		1504 M	
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
female	cauc.		June 28, 1932			36 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel General			housewife		own home	
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Annapolis				209 Chinquapin Road Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Henry Oaks			Della M. Dowling						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address			
no				214-26-0329		Charles H. Tapp - same as #13 above			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Carcinoma of breast c gen. metastasis</u>									1 yr.
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 9/3/1968, to 1/7/1969, that (I) (we) last saw the deceased alive on 1/7/69 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
S. BORSSUCK, M.D.,									1/8/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					Amos Garrett Blvd., Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/9/69		Hillcrest Cemetery		Annapolis Md.			
24. FUNERAL DIRECTOR					25a. RECEIVED BY				
Hopling Funeral Home - Annapolis, Md.					10 1969				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. -Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR A M		
TA Florence NMN			TAYLOR			January 25 1969			9:10		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. COUNTY OF DEATH		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Female		Caucasian		June 21, 1883		85		Anne Arundel			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)	
England		U.S.A.				Anne Arundel		Annapolis		General Hospi	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET AND NUMBER		13c. CITY OR TOWN		13d. STATE	
HOME		HOUSEWIFE				3 Eastern Avenue		Annapolis		Maryland	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		
Isaiah			Eliza			NO			-		
17. INFORMANT			18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			20a. AJTPSY?		
Tom G. Taylor #13			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral bronchial</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cachexia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis, general and cerebral</u>			Jan 17 '69			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING		
KAY			2 days			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
			6 weeks			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		
			many years			21f. LOCATION			22a. I certify that (I) <u>husband</u> attended the deceased from <u>November 6, 1968</u> to <u>January 25, 1969</u> , that (I) <u>yes</u> last saw the deceased alive on <u>January 24, 1969</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death		
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
Charles W. Kinzer			January 27, 1969			Charles W. Kinzer, M. D.			16 Murray Avenue, Annapolis, Md. 21401		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			1-28-69			CEDAR Bluff			Annapolis, Md.		
24. FUNERAL DIRECTOR			25a. DATE OF REGISTRATION			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE		
John M. Taylor			Jan 28 1969			[Signature]			[Signature]		



20



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00243

00240

1. DECEASED NAME (Type or print) First Middle Last JOHN CONOVER TENEYCK		2a. DATE OF DEATH Month Day Year January 31 1969		2b. HOUR 1:06 PM	
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 27 June 1899	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel		9. COUNTY OF DEATH Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Navy	
12b. KIND OF BUSINESS OR INDUSTRY Government					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 65 Shipwright Street			
14. FATHER'S NAME First Middle Last John Conover Teneyck		15. MOTHER'S MAIDEN NAME First Middle Last Laura Breckinridge			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give war or dates of service) 1920-1940		16b. SOCIAL SECURITY NO 120-05-7145	
17. INFORMANT Hendrix		Address NMN Teneyck Fayetteville, New York			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Cerebral Infarct and Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombosis of Right Carotid Artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED Where <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael F. Fornes MD		DEGREE MD		22c. DATE SIGNED 2-1-69	
22d. PHYSICIAN'S NAME (Type) F. FORNES		22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 2-1-69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
23d. LOCATION (City or Town) (County) (State) Bhadenburg P.G. MD.		23e. ADDRESS John M. Saylor & Sons Annapolis, Md.		23f. REC'D BY REGISTRAR FEB 5 1969	
23g. REGISTRAR'S SIGNATURE					



FOR STATE  
HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR	
Maude V. Thomasson						ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/>			1	9	1969	12 M	
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 24 HRS		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
F	W	5-1-23	45 YRS	MONTHS	DAYS	HOURS	MIN	Jan.		4	1969	12:15	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Wash. D.C.		Anne Arundel				Anne Arundel							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie			North Arundel			Housewife			at home				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Md.			Anne Arundel			Glen Burnie						213 Otis Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Oscar A. Phillips			Florence J. Kessler										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			In			John B. Thomasson			Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u>												Sudden	
78X DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
				HOUR A.M. P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				1-4-69					
E. Linhart				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				A.A. Co.					
ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)	
Burial				1-7-69				Washington National				Shutland Maryland	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
W. W. Chambers				6517-11 St. S.E.				JAN 14 1969				Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

30242

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

30242

1 DECEASED NAME (Type or print) First Middle Last JOHN RISEON TUCKER			2a DATE OF DEATH Month Day Year JAN 5 1969		2b HOUR M
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH DEC 14, 1900		6 AGE (In years last birthday) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) ANNAPOLIS	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ANNE ARUNDEL Md		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) H.A. GEN. HOSPT. PIPEFITTER		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY US Gov.	
13a US-AL RESIDENCE (Where deceased lived, admission) STATE MD	13b COUNTY AA. CO	13c CITY OR TOWN ANNAPOLIS	13d INSIDE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 106 TUCKER ST.	
14 FATHER'S NAME First Middle Last JOHN W. TUCKER		15 MOTHER'S MAIDEN NAME First Middle Last ANNIE M CROSS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.	17 INFORMANT Address MRS. VIOLET E. TUCKER # 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTEROSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>9 YEARS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/13, 1960</u> , to <u>1/5, 1969</u> , that (I) (we) lost saw the deceased alive on <u>1-3-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>John M. Taylor</i>		DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED 1-6-69	
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS			
23a BURIAL, CREMATION, REMOVED (Specify)	23b DATE JAN 8 1969	23c NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM.		23d LOCATION (City or Town) (County) (State) GLEN BURNIE AAGMD	
24 FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD		25a REC'D BY REGISTRAR JAN 9 1969		25b REGISTRAR'S SIGNATURE <i>John M. Taylor</i>	

VMD 154 69

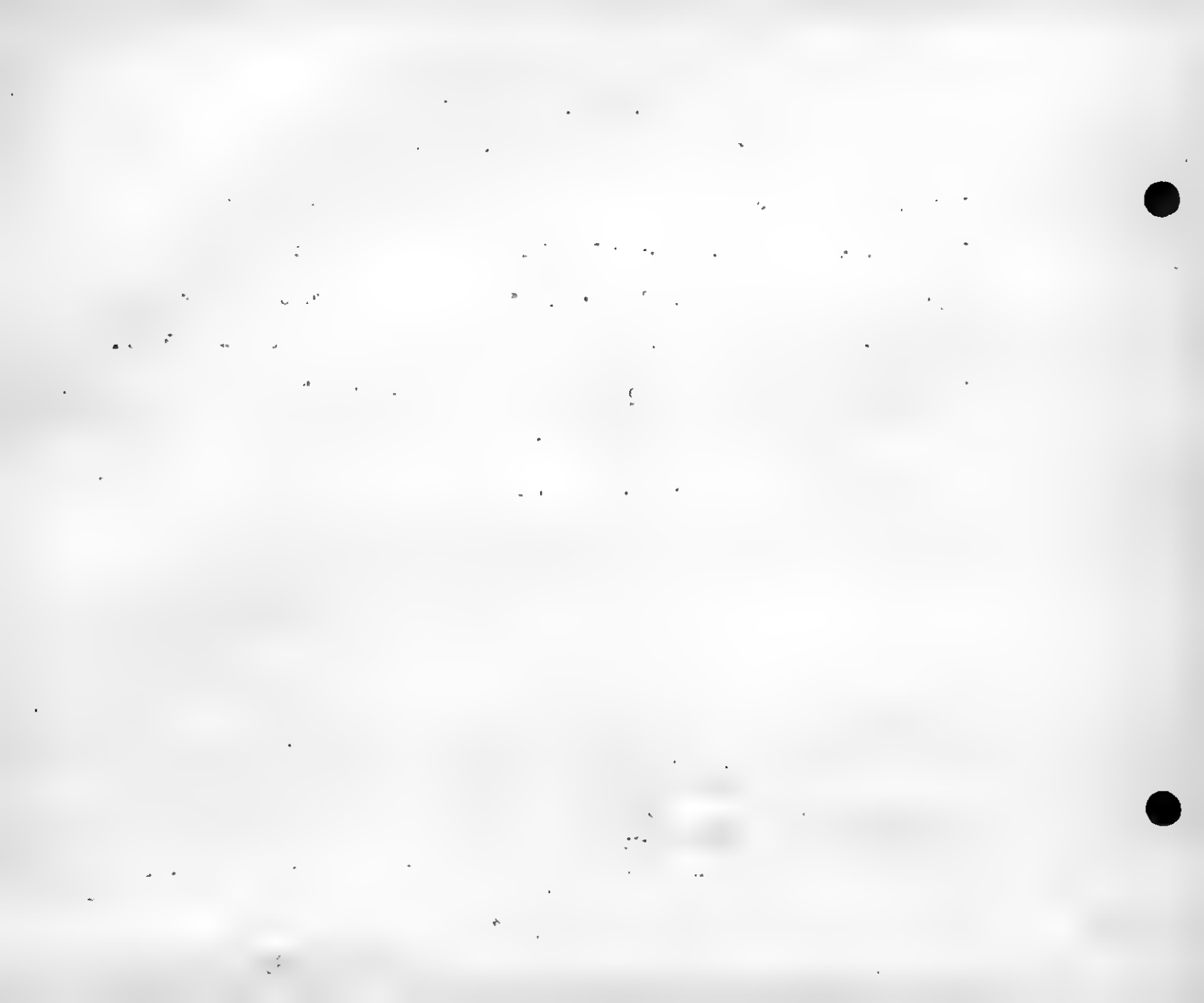


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print)			First MARK			Middle CHRISTOPHER			Last URICK			2a. DATE OF DEATH JAN Month 15 Day 1969 Year			2b. HOUR 7:37 a.m.		
3 SEX Male			4 RACE White			5. DATE OF BIRTH 14 Jan 1969			6 AGE (In years lost birthday) YRS.			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. HOURS		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.								
10. CITY OR TOWN OF DEATH Ft Geo G. Meade			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. KIMBROUGH ARMY HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY N/A								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Hanover			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Route #2, Box 161					
14. FATHER'S NAME First Albert			Middle Urick			Last Urick			15. MOTHER'S MAIDEN NAME First Patricia			Middle Gertrude			Last Hartman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) No			(If yes give year or dates of service) N/A			16b. SOCIAL SECURITY NO. None			17. INFORMANT Address Albert Urick, Route #2, Box #161, Hanover, Md								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY.																	
IMMEDIATE CAUSE (a) Aspiration Pneumonia																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) Abruptio Placenta												16 Hrs					
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State		
22a. I certify that I (this hospital) attended the deceased from 14 Jan, 1969, to 15 Jan, 1969, that I (we) last saw the deceased alive on 15 Jan, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (do not) view the body after death.																	
22b. SIGNATURE <i>Herbert Spolter</i>			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 15 Jan 69								
22d. PHYSICIAN'S NAME (Type) HERBERT SPOLTER, CPT, MC			22e. ADDRESS US KIMBROUGH ARMY HOSP, FT MEADE, MD														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN 17 '69			23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL			23d. LOCATION (City or Town) BALTIMORE, MD			(County)			(State)		
24. FUNERAL DIRECTOR ADEL WITZKE			ADDRESS FLEISCHER CITY.			25a. REC'D BY REGISTRAR DATE JAN 16 1969			25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>								

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR Min
William			C.		Voss	1 17 69			10 A
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
M	W		4-30-13			55 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		USA				Anne Arundel			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie			North Annapolis Convalescent Center			FURNACE OPERATOR		KAISER ALUM.	
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INS. OF CITY, J.M.T.S?	
BALTO. CO. Md.			ARBITUS			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3805 DOOLIDGE AVENUE XXXXXXXXXXXXXXXX	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Wilhelm			P.		Voss	anna m. cogswell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			
no			216 03 3686			MRS. HELEN M. PAVLICK(daughter) Pasadena Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Astrocytoma, Grade IV, right temporal									
DUE TO, OR AS A CONSEQUENCE OF (b) Tumor (glioblastoma multiforme) 3 months									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.(a)									
none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC)		21e. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/17, 1968, to 1/17, 1969, that (I) (we) last saw the deceased alive on 1/17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
R.M. McLaughlin, M.D. DEGREE									
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. DATE SIGNED									
1/17/69									
22d. PHYSICIAN'S NAME (Type)									
R.M. McLaughlin, M.D.									
22e. ADDRESS									
3708 Mountain Rd. Pasadena, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		Jan. 21, 1969		Landon Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR									
R. V. Singleton									
ADDRESS									
Singleton Funeral Home									
Glen Burnie, Md.									
25a. REC'D BY REGISTRAR									
JAN 22 1969									
25b. REGISTRAR'S SIGNATURE									
Charles J. J.									

30

30 30 X

30 30 X

30 30 X

30

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00241

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00245

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Robert			Warfield			Month Day Year			P M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
M	W	6-18-53	15 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Maryland		U.S.A.		WIDOWED		DIVORCED		A.A.Co.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			North Arundel Hosp.			Student			School		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
Maryland			Anne Arundel			Severn			Box 331 - Quarterfield		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Barnesley			Warfield			Elizabeth M. Gardner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			Unknown			Mrs. Elizabeth Warfield (mother)			Same As #13		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Gun Shot - wound. abdomen											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				HOUR A.M. P.M.				Gun Shot - wound. abdomen			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or R.F.D. No City or Town County State			
				Home				Qualifues Road ARLCO MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASS. STANT MEDICAL EXAMINER				1-6-69			
E. Linhardt				DEPUTY MEDICAL EXAMINER				A.A.Co.			
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, or other disposal		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jan. 9, 1969		Glen Haven Mem. Park		Glen Burnie, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
R.V. Singleton		Bingleton Funeral Home		JAN 8 1969		Charles Judge					
		Glen Burnie, Md.									

MAILED  
JAN 14 1969



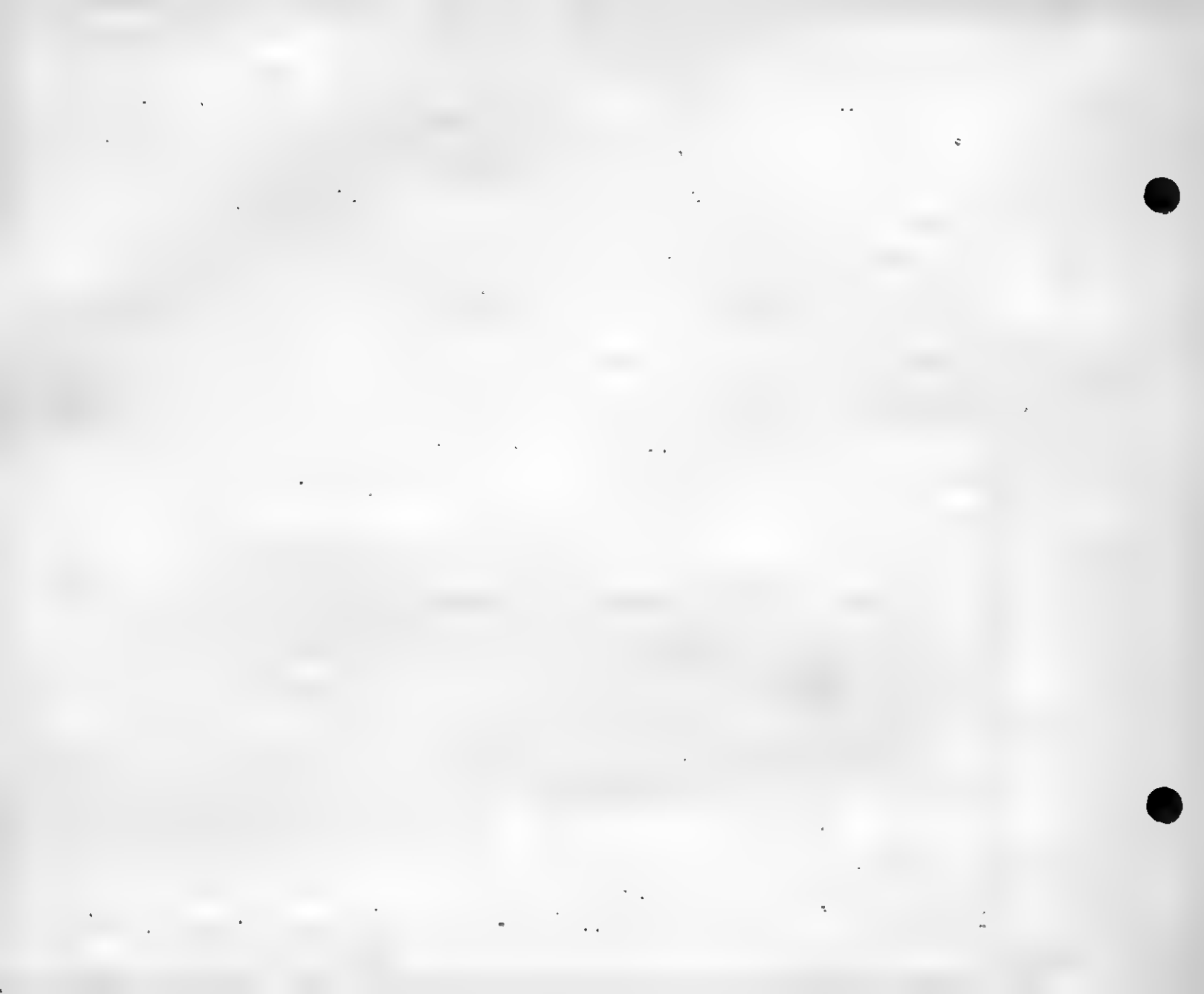
2  
2  
2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 8 Film 410 3/10/69 kk										MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01926									
Item 13 Film 410 3/5/69 kd 00246										CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>Lillian</i>					First Middle Last <i>Washington</i>					2a DATE OF DEATH 1 Month 17 Day 69 Year					2b HOUR 2 P. M.				
3 SEX <i>Female</i>			4 RACE <i>Negro</i>			5 DATE OF BIRTH <i>4-1-16</i>			6 AGE (In years last birthday) <i>52 YRS.</i>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY? <i>USA</i>					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH <i>Anne Arundel</i>				
10 CITY OR TOWN OF DEATH <i>CROWNSVILLE</i>					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>STATE HOSP</i>					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>					13b COUNTY <i>Anne Arundel</i>					13c CITY OR TOWN <i>Crownsville</i>					13d INS-OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13e STREET AND NUMBER <i>c/o Mrs. Blanche B. Dawson</i>					14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Liver, pleural, peritoneal &amp; L.O. metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>carcinoma of the left breast</i> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <i>10-20, 1968</i> , to <i>1-17, 1969</i> , that (I) (we) lost the deceased alive on <i>1-17-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.																			
22b. SIGNATURE <i>Alberto Gonzalez</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type) <i>Alberto Gonzalez</i>					22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE <i>2.24.69</i>					23c. NAME OF CEMETERY OR CREMATORY <i>C. of Md. Med. School</i>					23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>				
24. FUNERAL DIRECTOR					ADDRESS					25a. REC'D BY REGISTRAR DATE <i>FEB 28 1969</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>				



## CERTIFICATE OF DEATH

00246

1 DECEASED-NAME (Type or print) <b>Arthur R. Watson</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>6</b> Year <b>69</b>			2b. HOUR <b>6:50 PM</b>	
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>3-15-99</b>		6 AGE (In years last birthday) <b>69</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel County</b> Md	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUA. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Anne Arundel</b>		13c CITY OR TOWN <b>Pasadena</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>Route 6 Box 20</b>		14. FATHER'S NAME First Middle Last <b>UNK</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>UNK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If you gave war or dates of service)		17 INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic aortic lateral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>days</b> <b>years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary embolism</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/21</b> , 19 <b>68</b> , to <b>1/6</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Max C Frank</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>1/6/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>MAX C FRANK MD</b>				22e ADDRESS <b>4215 SE Ritchie Hwy Glen Burnie MD</b>			
23a BURIAL, CREMATION, REMOVAL, (Specify) <b>BURIAL</b>		23b DATE <b>8 JAN, 1969</b>		23c NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem.</b>		23d LOCATION (City or Town County State) <b>Glen Burnie, AA Md.</b>	
24 FUNERAL DIRECTOR <b>ITICKLEY Funeral Home Glen Burnie</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>1968</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VRLA'S 14  
JAN 15 1969



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <i>Charles Mathias Weiger</i>			2a DATE OF DEATH Month <i>January</i> Day <i>11</i> Year <i>1969</i>			2b HOUR <i>1 A.M.</i>						
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>November 4, 1894</i>		6 AGE (In years last birthday) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.						
10. CITY OR TOWN OF DEATH <i>Severna Park, Md.</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Devonshire Ct. 540</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Hosiery trimmer</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Hosiery</i>						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Anne Arundel</i>		13c CITY OR TOWN <i>Severna Park</i>		13d INS. DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>546 Devonshire Court</i>				
14. FATHER'S NAME First <i>JOSEPH</i> Middle <i>WEIGER</i> Last <i>WEIGER</i>			15. MOTHER'S MAIDEN NAME First <i>Catherine Ann</i> Middle <i>Schultz</i> Last <i>Schultz</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)			16b SOCIAL SECURITY NO. <i>181-03-1146</i>		17 INFORMANT <i>Mrs. Anna Weiger</i>			Address <i>same</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>4337</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>none</i>												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>6/15/69</i> , 19 <i>69</i> , to <i>1/11/69</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/11/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>R.M. McLaughlin</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/11/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>					22e. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>							
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-13-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cem.</i>		23d LOCATION (City or Town) (County) (State)						
24 FUNERAL DIRECTOR <i>Severna Park Co. of Mort. &amp; Burial S. Farranco,</i> <i>Severna Park, Md. 2146</i>					25a. REC'D BY REGISTRAR <i>DIAN 14 1969</i>		25b REGISTRAR'S SIGNATURE <i>William Dudge</i>					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Filing 109 2/17/69 kk 1025										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30248			
1 DECEASED NAME (Type or Print) First ALICE Middle E. Last (WILFONG) WELFONG										2a. DATE KNOWN OF DEATH Month Jan. 23, Year 1969				2b HOUR 1:15 PM									
3 SEX Female		4 RACE White		5 DATE OF BIRTH APRIL 17, 1941		6 AGE (in years last birthday) 27 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Jan. Day 23, Year 1969				2d HOUR 1:15 PM							
7a BIRTHPLACE (State or foreign country) NEW JERSEY				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Anne Arundel Md.											
10 CITY OR TOWN OF DEATH Glen Burnie				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWORK				12b KIND OF BUSINESS OR INDUSTRY OWN HOME											
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland				13b COUNTY Anne Arundel				13c CITY OR TOWN Glen Burnie				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 174 Virginia Apt. J.									
14. FATHER'S NAME First FRANK Middle H. Last EGGERS										15 MOTHER'S MAIDEN NAME First MARY Middle L. Last McDONALD													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) NO				16b. SOCIAL SECURITY NO. unknown				17. INFORMANT ADDRESS Mr. Orville Wilfong (husband) Same as #13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i>				EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED 1/24/69											
23a BURIAL, CREMATION, REMOVAL Burial				23b. DATE January 27/69				23c NAME OF CEMETERY OR CREMATORY Holy Name Cemetery				23d LOCATION (City or Town) Jersey City, New Jersey (County) (State)											
24 FUNERAL DIRECTOR <i>R. Singleton</i>				ADDRESS Singleton Funeral Home Glen Burnie, Maryland				25a RECD BY REGISTRAR DATE JAN 27 1969				25b REGISTRAR'S SIGNATURE <i>William J. Young</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 2a should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>Mattie</b> First <b>EX</b> Middle <b>M.</b> Last <b>Wessler</b>						2a. DATE OF DEATH Jan. 21 1969			2b. HOUR 9:30 P.M.			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH 7-26-91			6. AGE (In years last birthday) 77 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.						
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and address) <b>North Arundel</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Seamstress (Ret.)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>711 Mayo Road</b>		
14. FATHER'S NAME First <b>August</b> Middle <b>H.</b> Last <b>Rehkop</b>				15. MOTHER'S MAIDEN NAME First <b>Minnie</b> Middle <b>Beasing</b> Last <b>Beasing</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>500-10-9231</b>		17. INFORMANT <b>Mrs. Irene M. Stahrman (daughter)</b>				Address <b>#23 Same as</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>CVA.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertension.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Fracture of Rt radius + Symptomatic aortic.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension.</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Arsenio Santos MD</b>						22c. DATE SIGNED <b>1, 22, 69</b>						
22d. PHYSICIAN'S NAME (Type) <b>ARSENIO SANTOS</b>						22e. ADDRESS <b>325 Hospital Dr. GB Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/26/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blackburn Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Blackburn, Missouri</b>				
24. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>				25a. REC'D BY REGISTRAR <b>JAN 23 1969</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
24. ADDRESS <b>Glen Burnie, Maryland</b>				25a. DATE <b>JAN 23 1969</b>								



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or Print)			First <b>CHARLES</b>			Middle <b>W.</b>			Last <b>WHEELER</b>			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>		2b. HOUR <b>3:30</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>9-3-1922</b>		6 AGE (in years last birthday) <b>46</b> YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>24</b> Year <b>1969</b>		2d. HOUR <b>3:30</b>			
7a BIRTHPLACE (State or foreign country) <b>Cambridge Md</b>				7b CIT ZEN OF WHAT COUNTRY? <b>U.S.</b>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <b>AnneArundel</b>					
10 CITY OR TOWN OF DEATH <b>Laurel</b>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Hill Ave. Laurel</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter</b>				12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b COUNTY <b>A. A.</b>				13c CITY OR TOWN <b>Laurel</b>				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>Hill Ave., Laurel</b>			
14 FATHER'S NAME First <b>Charles</b> Middle <b>W.</b> Last <b>Wheeler</b>						15 MOTHER'S MAIDEN NAME First <b>Rose</b> Middle <b>Frazier</b> Last <b>Frazier</b>											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16b SOCIAL SECURITY NO <b>WW 11 213-14-7422</b>				17. INFORMANT <b>Mrs. Wayne Smith</b>				ADDRESS <b>Oakley St. Cambridge</b>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Craniocerebral injuries</b>																	
768X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b>																	
(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <b>1 P.M. 1 24 19 69</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Subject struck about the head with object</b>									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>				21f LOCATION Street or R.F.D. No. <b>Hill Ave.</b> City or Town <b>Laurel</b> County <b>A. A.</b> State <b>Md.</b>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>				M.D. <b>Ronald N. Kornblum, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <b>1/25/69</b>					
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
								ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b DATE <b>1/27/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>				23d LOCATION (City or Town) (County) (State) <b>Cambridge Dorchester Md.</b>							
24 FUNERAL DIRECTOR <b>Kenneth R. Harrod</b>				ADDRESS <b>Cambridge Md. 21613</b>				25a RECD BY REGISTRAR DATE <b>JAN 29 1969</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-17-68  
30M REV. 1-1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

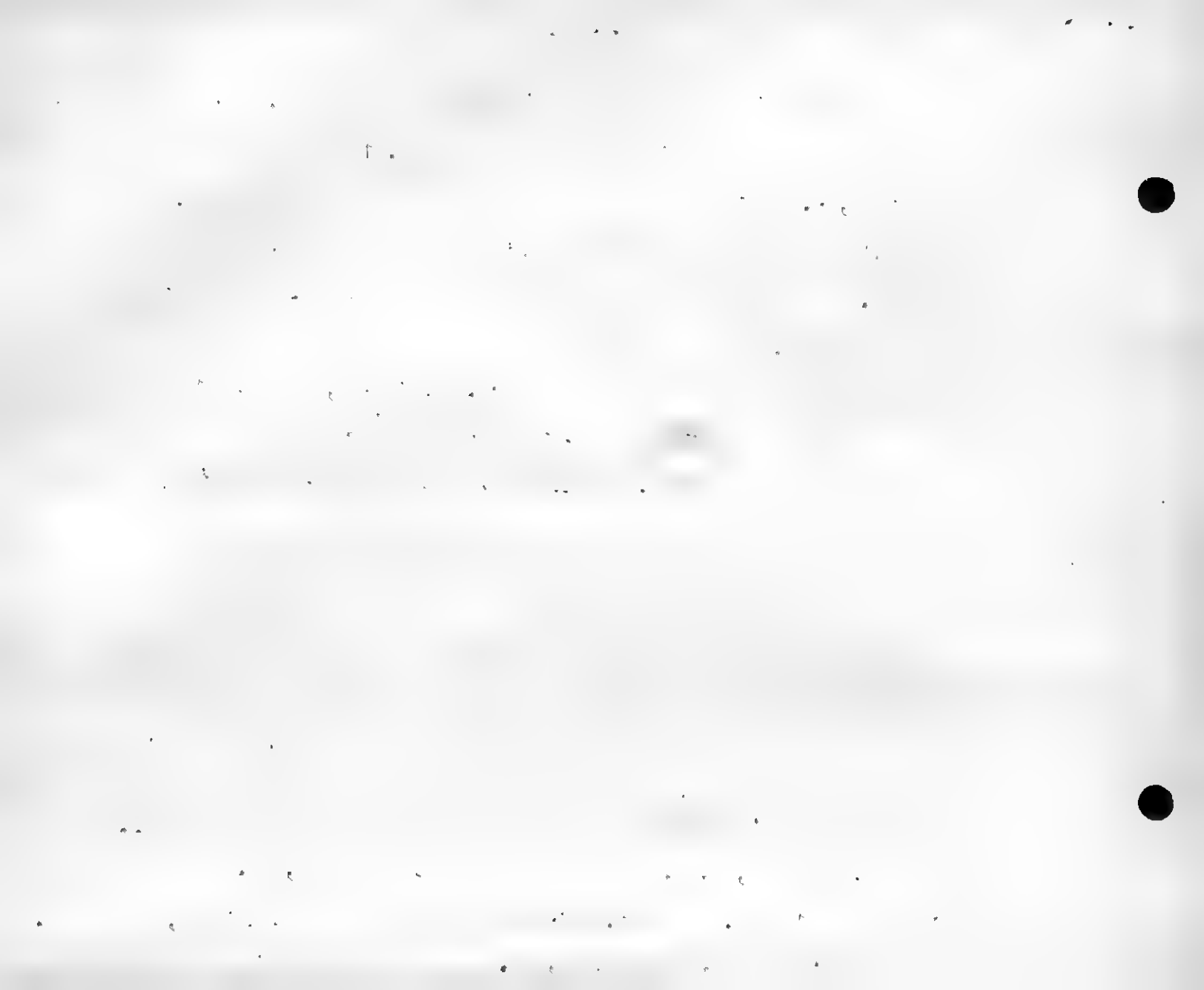
CERTIFICATE OF DEATH

025

00251

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Vasseni					Wilkinson	Jan. Month 8 Day 1969 Year			2:00pm		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		23 Aug. 1875		93 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.		USA				Anne Arundel Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Bay Manor Nursing Home				Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.			AA		Severn			Quarterfield Road			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Matthias					Zoeller	Mary					Hoppe
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
no					Mrs. Naomi Care, same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>Coronary</del> Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) <del>Arteriosclerotic</del> Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) <del>1 week</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2/23, 1965, to 2/23/1969, that (I) (we) last saw the deceased alive on 2/23/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ray Smith</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10 Jan. 69				
22d. PHYSICIAN'S NAME (Type) Ray Smith, M.D.					22e. ADDRESS Severna Park, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		11 Jan. 69		Mt. Olivet Cemetery		Baltimore, Md.					
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Kirkley Funeral Home, Glen Burnie, Md.					JAN 13 1969		<i>Charles Judge</i>				

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

00250

00252

1 DECEASED NAME (Type or print) <b>Reese</b>			Middle (none)			Last <b>WIMBROW</b>			2a. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1969</b>			2b. HOUR P. <b>3:00 M</b>			
3. SEX <b>Male</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>April 9, 1892</b>			6 AGE (In years last birthday) <b>76</b> YRS			IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Anne Arundel</b>			Md			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Anne Arundel Gen. Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
13a USUA. RESIDENCE (Where deceased admission) STATE <b>Maryland</b>			13b COUNTY <b>Anne Arundel</b>			13c CITY OR TOWN <b>Annapolis</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>100 Archwood Ave.,</b>			
14. FATHER'S NAME First <b>JOHN</b> Middle <b>M</b> Last <b>WIMBROW</b>			15 MOTHER'S MAIDEN NAME First <b>ELIZA I.</b> Middle <b>PARSONS</b> Last												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT <b>NINA P. WIMBROW #13</b>			Address						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>5 YEARS</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PARKINSONISM</b>															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (a) (this hospital) attended the deceased from <b>12-19, 1968</b> to <b>1-10, 1969</b> , that (b) (we) last saw the deceased alive on <b>1-10, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death.															
22b SIGNATURE <b>Edward S. Beck</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <b>1-11-69</b>						
22d PHYSICIAN'S NAME (Type) <b>Edward S. Beck, M.D.</b>						22e ADDRESS <b>73 Franklin St., Annapolis, Md.</b>									
23a B. RIAL CREMATION, (REMOVAL Specify)			23b DATE <b>1/14/1969</b>			23c NAME OF CEMETERY OR CREMATORY <b>PARSONS CEM.</b>			23d LOCATION (City or Town) (County) (State) <b>SALISBURY MD.</b>						
24 FUNERAL DIRECTOR <b>JOHN M. TAYLOR (Sons Annapolis)</b>						ADDRESS			25a REC'D BY REG STAFF <b>MAN 15 1969</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it is to be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bur or transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P.		
Russell			(none)		WIMPLE	January 28 1969		5:30 M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		
Male		Negro		July 14, 1884		84 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
North Carolina		U.S.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel Gen. Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt-3, Box 43A,	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Louis Wimple			Sylvia Wimple							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
					Katie Breashers (Wimple)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 1619 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Cachexia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 months 1 year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Malnutrition due to primary carcinoma of larynx										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) <del>(did not)</del> attended the deceased from April 12, 1966, to January 28, 1969, that (I) <del>(do)</del> last saw the deceased alive on January 28, 1969, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(do)</del> (did) <del>(not)</del> view the body after death.										
22b. SIGNATURE Charles W. Kinzer						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED January 29, 1969		
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.						22e. ADDRESS 16 Murray Ave., Annapolis, Md. 21401				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2-1-1969		Annapolis Neck		Annapolis Md				
24. FUNERAL DIRECTOR William Reese						25b. REC'D BY REG. STRAR FEB 3 1969		25c. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

10251

10251

1. DECEASED-NAME (Type or print) <b>MARY</b> First <b>E.</b> Middle <b>YEATMAN</b> Last			2a. DATE OF DEATH Month <b>JAN</b> Day <b>31</b> Year <b>1969</b>			2b. HOUR <b>8:15 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>1 Jan. 1886</b>		6. AGE (in years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>D.A. Co.</b>				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Randall Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Home maker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>D.A. Co.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 3 - Box 447</b>	
14. FATHER'S NAME First <b>HARRY</b> Middle <b>(UNKNOWN)</b> Last			15. MOTHER'S MAIDEN NAME First <b>Mignon</b> Middle <b>KING</b> Last <b>HOFFCK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO <b>217-52-9652</b>		17. INFORMANT Address <b>Jeanette Ritterbusch (daughter)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes mellitus</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>5 years</b> <b>5 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>none</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1962</b> to <b>January 31, 1969</b> , that (I) (we) lost the deceased alive on <b>January 30, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>R.M. McLaughlin</b>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>2/1/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin</b>					22e. ADDRESS <b>3708 Mountain Rd. Pasadena, Md. 21222</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2/3/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto Maryland</b>				
24. FUNERAL DIRECTOR <b>Robert Eugene Singleton Funeral Home / Glen Burnie</b>					25. REG'D BY REGISTRAR <b>FEB 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00255

1. DECEASED-NAME (Type or Print) First Middle Last <b>SANDRA JEAN YOUNG</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> <b>Jan. 6 1969</b>			2b. HOUR M <b>8</b>	
3. SEX <b>female</b>	4. RACE <b>cauc.</b>	5. DATE OF BIRTH <b>April 18, 1961</b>	6. AGE (In years last birthday) <b>8</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS <b>1 6</b>	IF UNDER 24 HRS. HOURS MIN. <b>1 6</b>	2c. DATE PRONOUNCED DEAD Month Day Year <b>1 6 1969</b>	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.		
10. CITY OR TOWN OF DEATH <b>Davidsonville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fatuxent Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>elem. school</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Davidsonville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Gen. Del.</b>	
14. FATHER'S NAME First Middle Last <b>Bobby Eugene Young</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Shirley Temple Perry</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT ADDRESS <b>Bobby E. Young - same as #13 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>814.7 Multiple Injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>1-6 1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Slunk &amp; bump</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>R214</b> <b>PPCo</b> <b>MS</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. Linbrant</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-6-69</b> <b>PPCo</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/10/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Episcopal</b>		23d. LOCATION (City or Town) (County) (State) <b>Odenton</b> <b>PPCo</b> <b>Md.</b>	
24. FUNERAL DIRECTOR: <b>HOPPING FUNERAL HOME - Annapolis, Maryland</b>				25a. REC'D BY REGISTRAR <b>JAN 10 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00225

0009 D1-101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00255												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00256			
Item 6 Film 0409 2/10/69 kk												CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)						First		Middle		Last		2a. DATE OF DEATH						2b. HOUR									
Joseph										Zink		Month 1 Day 6 Year 69						2:55a M									
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Male			White			6/24/03						66 65 RS.			MONTHS DAYS		HOURS MIN										
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH															
Lithuania				USA								Anne Arundel Md.															
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY									
Crownsville						Crownsville State Hospital																					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER															
Maryland						Balto		Balto		YES <input type="checkbox"/> NO <input type="checkbox"/>		unknown															
14. FATHER'S NAME						First		Middle		Last		15. MOTHER'S MAIDEN NAME						First Middle Last									
Joseph										Zink		Nellie						Didwall									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT						Address									
yes						Army						unknown						Hospital Records, Crownsville State Hospital									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) Pneumonitis																											
DUE TO, OR AS A CONSEQUENCE OF																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																											
(b) DUE TO, OR AS A CONSEQUENCE OF																											
(c)																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																											
Chronic brain syndrome																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
												YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
				HOUR A.M. Month Day Year P.M. 19																							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION																			
White <input type="checkbox"/> Not while at work <input type="checkbox"/>								Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 9/8, 19 66, to 1/6, 19 69, that (I) (we) last saw the deceased alive on 1/6/ 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE																		22c. DATE SIGNED									
Charles R. Venter, M.D.																		1/6/69									
22d. PHYSICIAN'S NAME (Type)																		22e. ADDRESS									
Charles R. Venter, M.D.																		Crownsville State Hospital, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)															
1-28'69				1-28'69				U. Ford Wood. School				Baltimore, Md.															
24. FUNERAL DIRECTOR																		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
William Reese																		DATE JAN 30 1969				Charles Judge					

JAN 10 1964

JAN 10 1964

